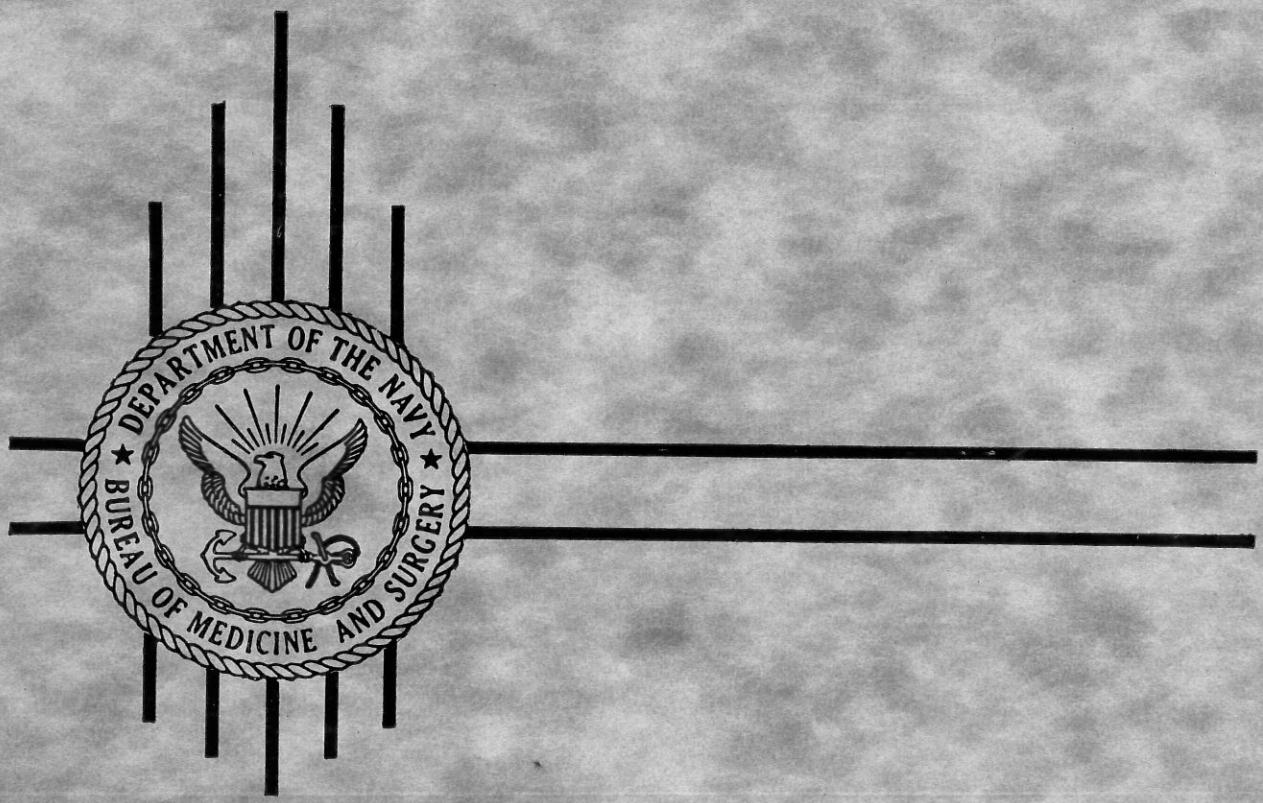
NAVMED P-5084

GUIDE FOR MEDICAL PERSONNEL AUGMENTING FLEET MARINE AND AMPHIBIOUS FORCES



1 JULY 1972

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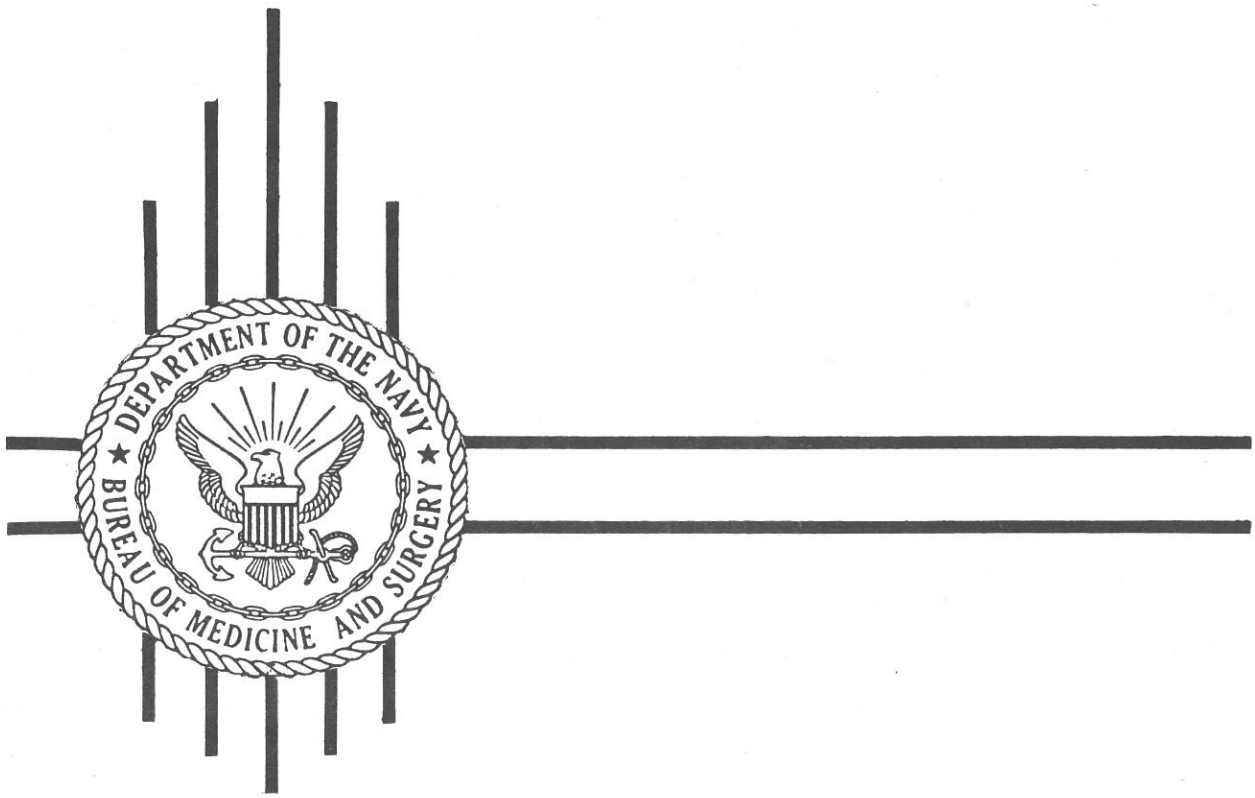

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FOREWORD

1 July 1972

This guide is to provide practical information for medical department personnel who have been designated to augment the medical resources of the Amphibious Forces and the Fleet Marine Force if required. Military contingencies, disaster relief operations, and fleet exercises are the principal occasions which require augmentation of the peacetime medical support structure of these Forces. Under the Joint Service concept, U.S. Navy medical personnel may be ordered to augment other U.S. Armed Forces or Allied medical units.

Numerous changes in the procedure for such augmentation have occurred since this Guide was first issued. The present edition supersedes the original undated (1965) edition, copies of which should be destroyed.

Emergency augmentation of Amphibious and Fleet Marine Force units may be accomplished by using teams or by using individual members of the medical department. Guidance for both groups is furnished. The information presented supplements and expands current official instructions. The Guide in itself is not directive in nature and if discrepancies exist the latest instruction shall be considered governing.

The capability to provide emergency medical/dental augmentation of the operating forces is a fundamental responsibility of the Navy Medical Department and all its members. Although it is seldom required, we must ensure that this augmentation is a smooth, successful operation. I have been pleased with the response of several of our teams called out for emergency deployment in the past few years. Practice is essential to maintain this capability and augmentation personnel may anticipate that they will periodically participate in Fleet exercises. Commanders of medical activities tasked to provide augmentees to the operating forces shall actively encourage designated augmentees to familiarize themselves with this publication.

Comments and recommendations for changes in future editions are invited.

G. M. Davis

G. M. DAVIS
Vice Admiral, MC, USN
Surgeon General

PREFACE

The primary responsibility of the medical department of the Navy is to provide medical care and treatment for the sick and injured members of the naval service. In peacetime this medical service is provided principally in the shore establishment where the majority of medical personnel are stationed. During this time the operating forces are maintained at reduced levels with a medical service geared to peacetime needs. In casualty-producing situations, the medical services of the operating forces must be expanded by additional personnel, facilities, and equipment. Therefore, experienced medical personnel working in the shore establishment can expect to be assigned to augment the operating forces when those forces are ordered into casualty-producing situations. When amphibious operations are imminent, the medical services of both the Fleet Marine Force and the Amphibious Forces of the Fleet require immediate augmentation.

Every member of the medical department should fully understand this augmentation concept, should recognize that it is the responsibility of the Medical Department to provide this kind of support, and should expect assignment (through one of the several methods of augmentation) to the operating forces in emergency situations.

Those in command of medical personnel in the shore establishment have the responsibility to select qualified individuals for augmentation duty, to train these personnel to be competent under field operating conditions, and to be certain that they are prepared for deployment. Those who are selected for augmentation duty have the responsibility to learn the nature and functions of the fleet and field organizations, and the requirements of their assignment. They must acquire a full understanding of the role they are to play in the operating forces and prepare themselves for emergency deployment. Medical personnel called upon to augment operating forces must be prepared to begin immediate casualty care and treatment procedures either in combat operations or disaster areas.

At times the medical specialist may be called upon to support an operating force engaged, not in combat, but in a diplomatic show of force. Medical personnel should understand the necessarily indefinite nature of such contingency operations and be prepared to adjust to the possible medical inactivity of the situation. Impatience regarding seemingly unnecessary delays and inactivity is understandable and every effort is made to preclude assignment of specialty teams to fleet operations which are unlikely to result in casualties.

The medical personnel who serve as augmentees fill a vital gap in the operating forces during emergency operations. Even if their services are never fully used, their presence assures the Navy and Marine Corps of full operational capability regardless of the situation.

This guide is designed primarily for medical department personnel who may be assigned, either individually or as members of teams, to augment the Amphibious Forces or Fleet Marine Forces during an emergency. Information of primary interest to hospital commanders and force medical officers is contained in current SECNAV, BUMED, and BUPERS Instructions.

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THE AUGMENTATION PLAN

THE CONCEPT

The short supply of medical personnel in the United States is also reflected in the medical staffing of the Armed Forces. In peacetime the number of medical department personnel is normally sufficient to provide health care for the members of the Armed Forces and their dependents. The limited medical man-power precludes staffing the operational forces at combat levels. Thus, in case of a war or emergency, additional medical personnel are needed in the operating theater. There are several ways of getting the needed medical personnel, such as calling up Reserve personnel, increasing recruiting and draft authority, and national mobilization. These methods require time, and in the meantime the operational forces must be supported by medical personnel attached to shore facilities. The Augmentation Plan was designed to provide medical personnel to satisfy such short notice needs.

The Augmentation Plan of the Navy Medical Department provides sufficient personnel (prior to mobilization) to staff two Marine Division Wing teams (Marine Amphibious Forces or "MAF's") and the amphibious ships necessary to deploy them. Should all of these augmentees be required, severe shortages will occur on the staffs of many of our hospitals. Authority to fill these vacancies will be requested if the forces are committed to combat or if the crisis proves to be of prolonged nature (as in Vietnam).

The Augmentation Plan is based on using teams of medical personnel, comprised of staff personnel of selected naval hospitals, provided with prepacked air-transportable equipment. Additionally, individual, predesignated medical personnel, principally attached to naval hospitals, may also be called upon to augment the operating forces. At any given time, a certain number of teams or individuals are on alert; the number on alert and their prescribed mount-out time depend upon the international political climate and the prescribed national defense alert level.

The rapid turnover of medical personnel in the Navy severely limits the number of individuals experienced in medical service with the operating forces. As a result, an attempt is made to have each team participate in an amphibious exercise at least once annually. These exercises may take place in any part of the world. Local training in traumatic surgery and the problems of dealing with large influxes of combat casualties is strongly encouraged.

BASIS FOR THE AUGMENTATION PLAN

The plan is promulgated in various official instructions from the Secretary of the Navy and the Bureau of Medicine and Surgery. The basic instructions are:

SECNAVINST 6440.1 series which assigns to certain Navy activities the responsibility for providing the Navy personnel needed to bring two Marine Amphibious Forces up to full combat strength for deployment. (This includes chaplains, legal officers, and naval gunfire specialists as well as medical personnel.)

BUMEDINST 6440.1 series which establishes surgical teams, surgical support teams, FMF (Fleet Marine Force) Surgical Platoon Cadres, and other special teams at various naval hospitals and describes the procedures for their deployment, training, equipping, etc.

Authorized Medical Allowance List #635 describes the equipment and supplies of a Navy surgical team.

Authorized Medical Allowance List #670 describes the equipment and supplies of an FMF Collecting and Clearing Company.

ORGANIZATIONS REQUIRING AUGMENTATION

The plan described in this manual provides for the care of casualties occurring in the landing force and in fleet elements in the immediate vicinity of the landing area. If the operation is a large one, or if the enemy has the potential for attacking other elements of the task force, additional augmentation may be required. The plan in this manual concerns itself only with landing-force elements and those ships used to transport the landing force, its equipment, supplies, and support elements. Other situations may require that other elements of the Navy (such as aircraft carriers) be specially augmented.

Landing force elements requiring augmentation:

Infantry and other battalions (artillery, engineer, etc.), companies, or detachments; headquarters organizations of larger units.

Medical units (division medical battalion, "Collecting and Clearing" companies "Clearing" platoons).

Aviation units (wings, air groups, provisional air groups, squadrons).

Amphibious force elements requiring augmentation:

Amphibious Assault Ship, General Purpose (LHA)

Amphibious Assault Ship (LPH)

Amphibious Transport, Dock (LPD) (if designated as casualty receiving ship or primary control ship)

Dock Landing Ship (LSD) (if designated as casualty receiving ship)

Amphibious Cargo Ship (LKA) (LKA-113 class only; if designated as casualty receiving ship)

Amphibious Transport (LPA) (if designated as casualty receiving ship)

Tank Landing Ship (LST) (if designated as casualty receiving ship)

Amphibious Command Ship (LCC)

Task Force and Landing Force Surgeons and Staffs; Task Force Medical Regulating Personnel

SKILL REQUIREMENTS

In the organization of medical teams, the senior member is designated officer-in-charge. Every effort is made to minimize his administrative responsibilities, but certain non-medical duties and responsibilities are inevitable. He should have a clear understanding of his disciplinary authority and limitations, and know how to make transportation arrangements for personnel and equipments, including enroute berthing and messing if required. He should know how to request local assistance (particularly if deploying in foreign countries) from appropriate U.S. military representatives. A clear understanding of the reporting and detachment procedures at the port of embarkation or rendezvous point is essential. He should know how to draft a message and how to use the naval communications systems. A medical officer, upon assignment as officer-in-charge

of a team, is advised to discuss these matters with the administrative officer of his hospital. Teams may be deployed with very little notice (twelve hours or less). The team may not know the details of the operation, the anticipated casualty loads, or the casualty evacuation scheme until they join the task force. The officer-in-charge must obtain this information from the ship, task force, or Marine element that he joins. It is his responsibility to see that the team accomplishes its assigned mission; the line officers to whom he reports will expect him to "take charge" and be fully responsible for his team, its members, and its equipment. In some cases a Medical Service Corps (MSC) officer has been assigned to the team to assume some of the administrative responsibilities; efforts are under way to make this the normal procedure.

AUGMENTATION ASSIGNMENTS

SPONSORS

The commanding officer of the sponsoring hospital has the responsibility for forming and maintaining teams. He is also responsible for designating individuals to meet any additional quotas and for ensuring readiness to deploy. Team members, individual augmentees, and alternates must be individually identified to BUMED semi-annually. The commanding officer must arrange training

programs for assigned personnel, and ensure the readiness of the team equipment block. He must make available to the team certain Bureau-furnished publications. He should be sure that all individuals receive the immunizations required for Alert Forces (BUMEDINST 6230.1 series), and that they possess identification tags, Geneva Convention cards, and working uniforms. Surgical Teams 4, 10, 15, and 19 (see chart of Designated Surgical Team Sponsors, page 7 will be provided Marine field utility clothing if activated as FMF Surgical Platoon Cadres. Field equipment ("782 gear": helmet, webbed belt, canteen, weapons, etc.) will be provided by the host Marine unit. The hospital commander may delegate some of these duties to the officers-in-charge of teams, but he remains responsible for their execution. (See recommended sponsor's check list, Appendix A.)

DEPLOYMENT PROCEDURES

The first notice a hospital commanding officer is likely to receive regarding deployment of augmentation personnel is an alerting call from BUMED; this will be followed by an official message. Normally, the Chief of Naval Operations authorizes direct liaison between the requesting authority and the hospital which has been selected to provide the augmentation team or personnel. Arrangement of transportation for augmentation personnel and equipment is the responsibility of the requesting authority (CINCLANTFLT, CINCPACFLT, CMC); he or a designated agency such as a Naval Air Logistic Control Office (NALCO), will advise the hospital commander whether or not military transportation will be available and the dates, places, and times of embarkation or rendezvous. Hospital commanders are authorized to arrange transportation to embarkation points or air-lift pickup points including commercial ground or air transportation if required. The requesting authority or his designated "action" agency or commander, gives the final notice to the hospital commander to deploy his team. The hospital commander then issues appropriate Temporary Additional Duty orders to the personnel involved. Rendezvous points may be distant (such as the Panama Canal Zone, Singapore, Athens, Okinawa, etc.). A team and its equipment may be air lifted to an aircraft carrier and subsequently transferred by helicopter to an amphibious force ship. Individual patience and tolerance are essential during the movement phase; medical personnel should realize that during a crisis situation there will be many high priority movements and they must be prepared to wait as necessary. A liaison officer or specific point of contact at rendezvous sites should be designated by the requesting authority; team leaders should make every effort to ensure that this has been done before departing. Certain teams are provided with U.S. Official Passports to expedite overseas movement.

The requesting authority also arranges the return transportation for augmentees. Because of heavy clinical loads at naval hospitals, commercial air travel should be requested by the team commander if military air travel will unduly delay (72 hours or more) return of personnel to their normal duty stations. The equipment block should be repacked, banded to prevent pilferage, and returned by government air or surface transportation. If the block does not return with the team, the team commander should request a formal receipt for the equipment from the ship or unit which assumes temporary custody of the repacked block. If portions of equipment or supplies must be left (as sometimes happens in disaster relief work) a personal copy of the orders, signed and

certified by competent authority, should be retained. This need not be military; in come cases diplomatic personnel or other government agencies (AID, etc.) may request retention of supplies/equipment on site.

COMMAND RELATIONSHIPS

Experience with special landing force operations has shown that it is generally preferable to order augmentees (as teams or individuals)to the Commander, Amphibious Task Force (or Group or Unit) who then further assigns them to an appropriate ship of the force. While embarked, a team commander is designated "Chief of Professional Service" and is responsible for professional coordination and performance of all embarked medical personnel in matters related to the reception, treatment, and disposition of casualties. His authority is limited to direct medical support of the operation. The ship's medical officer, if one is present, retains his normal responsibility and authority for medical matters relating to the ship and its crew and the arrangements for normal sick call for embarked troops. Troop and air group medical officers and corpsmen will function under the direction of the Chief of Professional Services in matters relating to casualty reception, care and disposition. Coordination between surgical teams is effected by the Amphibious Task Force Surgeon (the staff medical officer of the Commander, Amphibious Force or "CATF").

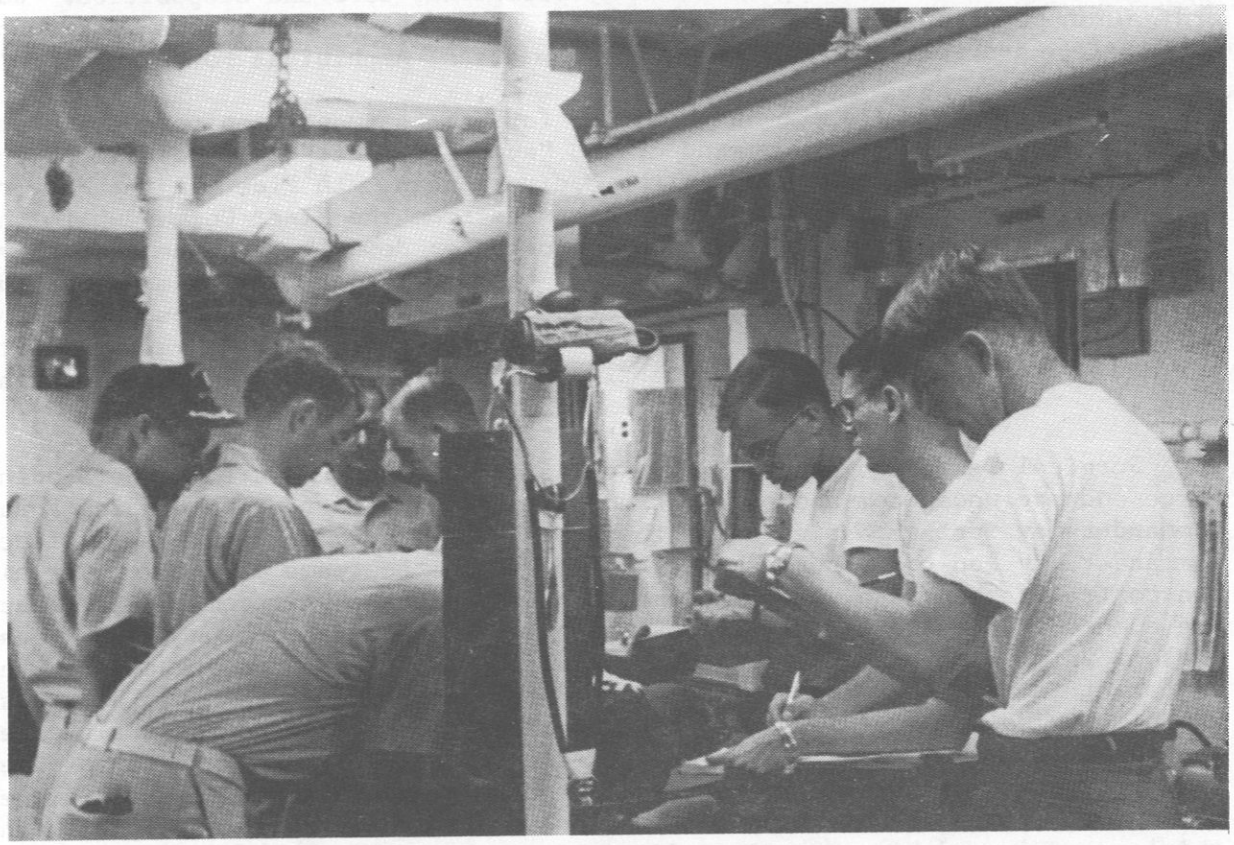
When deployed with the amphibious forces, augmentation personnel are normally under the military command of the "numbered fleet" commander (i.e. 2nd Fleet in the Atlantic, 6th Fleet in the Mediterranean, 7th Fleet in the Western Pacific). The military chain of command passes from the Fleet Commander to the Amphibious Task Force (or Group or Unit) commander down through the successive echelons of the Task Organization. Since task forces are tailor-made for the particular mission, it is most important that the team commander ascertain the exact chain of command under which the team operates. This is easily accomplished by examining the task organization as promulgated in the Operation/Plan order.

Surgical Teams assigned to Marine units are a detachment within the Landing Force and are under command of the Landing Force Commander. The Landing Force Commander may further assign teams to subordinate ground or air units. Either Commander may, on the other hand, elect to retain the teams directly under his own control rather than under the command of subordinate unit commanders. There are numerous technical reasons for electing one course or the other; these reasons vary according to the circumstances of the planned operation. The important thing is that the team commander must ascertain at an early date just who his immediate superior is so that he knows to whom to go for assistance, resupply, team movement, etc. Whether a team actually "reports to" a given ship's captain or is simply embarked in the ship and is reporting to a higher commander, early establishment of a close and friendly relationship with the ship's captain and his executive officer is important.

Individual augmentees fall into two classes: specialist personnel and general duty medical personnel. Individual augmentees are usually assigned to Fleet Marine Force Units. Fully trained specialists who are senior in rank, may initially find themselves attached to a USMC unit such as a Medical Battalion or "Collecting and Clearing" Company in which the commanding officer is

their junior. Because the augmentees are normally assigned for a short period of time, it would be wise to leave the junior officer, who is familiar with the unit and FMF operations, in command. If it appears that the augmentee may be with the unit for an extended period, he should discuss the desirability of his designation as commander of the unit with the appropriate common superior commander.

Secret security clearances for senior team members are particularly important. During the Cuban crisis several of our embarked surgical teams could not be fully briefed on the contingency plan because members lacked the necessary clearances. A situation in which team members could not be briefed obviously could create hardships and perhaps weaken the effectiveness of those teams. Command personnel should be particularly aware of this and take measures to correct the situation where it exists.



AUGMENTATION TEAMS

SURGICAL TEAMS

A surgical team is an organized, ready-reaction group of physicians, male nurses, and hospital corpsmen normally based in a naval hospital. A surgical

team is pretrained and equipped to provide rapid reinforcement of medical facilities (afloat or ashore) during amphibious operations, natural disasters, or other situations requiring additional surgical capability.

There are twenty surgical teams currently established. Each surgical team is organized so that when it is attached to a designed casualty receiving ship, it is able to man two operating rooms by using equipment provided in the surgical team supply block, existing shipboard facilities and shipboard personnel to augment the team staff. In some fleets, surgical supply blocks are prepositioned on certain ships.

Designated Surgical Team Sponsors

The following hospitals have been designated by BUMED Instruction 6440.1 series (1971) to sponsor surgical teams:

Naval Hospital	Surgical Team Number(s)
Bethesda, Maryland	1 and 2
Portsmouth, Virginia	3 and 4*
Great Lakes, Illinois	5 and 6
Oakland, California	7 and 8
San Diego, California	9 and 10*
Philadelphia, Pennsylvania	11 and 12
Boston, Massachusetts	13
St. Albans, New York	14
Camp Lejeune, North Carolina	15*
Charleston, South Carolina	16
Jacksonville, Florida	17
Long Beach, California	18
Camp Pendleton, California	19*
Guam, M.I.	20

*Surgical teams numbered 4, 10, 15, and 19 are dual-purpose teams and may be deployed either as surgical teams or, when reinforced, as FMF Surgical Platoon Cadres.

Navy surgical teams are designed, supplied, and equipped to provide direct surgical support to any medical facility. They are not self-sufficient, but must be provided shelter, power, berthing, messing, sterilizing equipment, and x-ray, laboratory, and laundry facilities. Surgical teams may or may not be required to bring and use their own surgical supply blocks. The normal situation with FMF surgical platoon cadres is to use supplies provided by the host units.

Surgical Team Composition

Each surgical team is composed of the following male members:

1 general surgeon (NOBC 0214)
1 orthopedic surgeon (NOBC 0244)
1 anesthesiologist (NOBC 0613)
1 anesthetist (NC) (NOBC 0910) (Male)
1 operating room nurse (NOBC 0970) (Male)
1 administrative officer (MSC) (NOBC 0802)

3 operating room technicians (primary NEC) (HM-8483)
2 operating room technicians (primary or secondary NEC) (HM-8483)
1 clinical laboratory technician (HM-8417)
1 medical x-ray technician (normally HMC or HMI) (HM-8352)
1 orthopedic cast room technician (HM-8489)
1 medical administrative technician (HMC) (HM-8442)
1 general service hospital corpsman (HM-0000)

The Surgical Team in Operation

The early establishment of close and cordial working arrangements with the ship's officers and crew is the key to a successful support mission. Whether the team is ordered to supplement the ship's crew, or simply to operate under the control of the task unit commander makes little difference. The officer-in-charge should establish good relationships with the ship's executive officer and through him keep the ship's captain fully informed as to the medical status, problems, and requirements. On large ships, such as the LHA and LPH, a medical officer is assigned to the ship. The team will operate from the ship's sick bay. A tactful approach will minimize friction.

When the team arrives at its assigned ship and the officer-in-charge has reported to the ship's executive officer and captain, an immediate familiarization survey of the ship's medical spaces should be undertaken. If the team has advance notice of its ship assignment, reference should be made to "Medical Capability Survey and Inventory of Ships of the Amphibious Force, U.S. Atlantic Fleet, October 1970".

The team may decide to use existing shipboard surgical equipment (such as on LHA's and LPH's) or may decide to unpack its own presterilized packs. If the casualty load is heavy and an additional operating or surgical dressing room is needed, the team can unpack and set up its folding operating table and lights (assistance from the ship may be required). The decision will be made by the Chief of Professional Services with the advice of the Amphibious Task Force surgeon if one is deployed.

The supplies carried in the surgical supply block are calculated to be sufficient for 100 major procedures. Surgical team resupply blocks are positioned at specific advanced locations and may be requested by a priority message to BUMED. Prior to acceptance of casualties, it is essential that the following points be determined and mutually agreed upon with the ship's personnel:

Casualty movement routes (casualties may arrive by helicopter or boat)
Triage area, equipment, personnel and procedures
Source of whole blood--arrangements for drawing from crew
Casualty overflow berthing spaces
Provision for feeding non-ambulatory patients
Preparation of skeleton clinical records
Required reports and their transmission
Medical communications channels, operators; requirements for secure voice transmissions

Method of further evacuation of casualties and decedents
Arrangement with an ordnance expert to remove and dispose of any possible live ordnance brought aboard by or with the casualties
Arrangement for stretcher bearers (four per litter) from ship's company or Marines
Preparation of a morgue refrigerator for storage of remains of the deceased in body bags. (If no designated morgue refrigeration space exists, request assignment of an existing refrigerator for this purpose and equip with temporary shelving or scantling to support remains.)

Early arrangements should be made to evacuate appropriate patients to CONUS hospitals through the JAMRO (Joint Armed Forces Regulating Office) regulating system, following the evacuation policy established for the operation by SECDEF/JCS or area commander. Such patients will be aeromedically evacuated by MAC (Military Airlift Command) as soon as a landing field can be secured. Until such evacuation is possible, berthing, messing, and nursing care must be provided to those patients. The Task Force Surgeon, the commanding officer of the ship, and the CTF should be kept apprised of the availability of operating rooms, post-operative beds, and any backlog (in time increments).

In medium and large task organizations, there will be a "Force Surgeon" assigned to the force commander's staff. He should be contacted and, if possible, visited. He will be keenly interested in the team and will be able to expedite requests for assistance. In all but the smallest operations he will regulate flow of the casualties to and from the various casualty receiving ships. When the team commander needs a "doctor-to-doctor" talk to resolve his problems, the Force Surgeon is the man to contact.

SURGICAL SUPPORT TEAMS

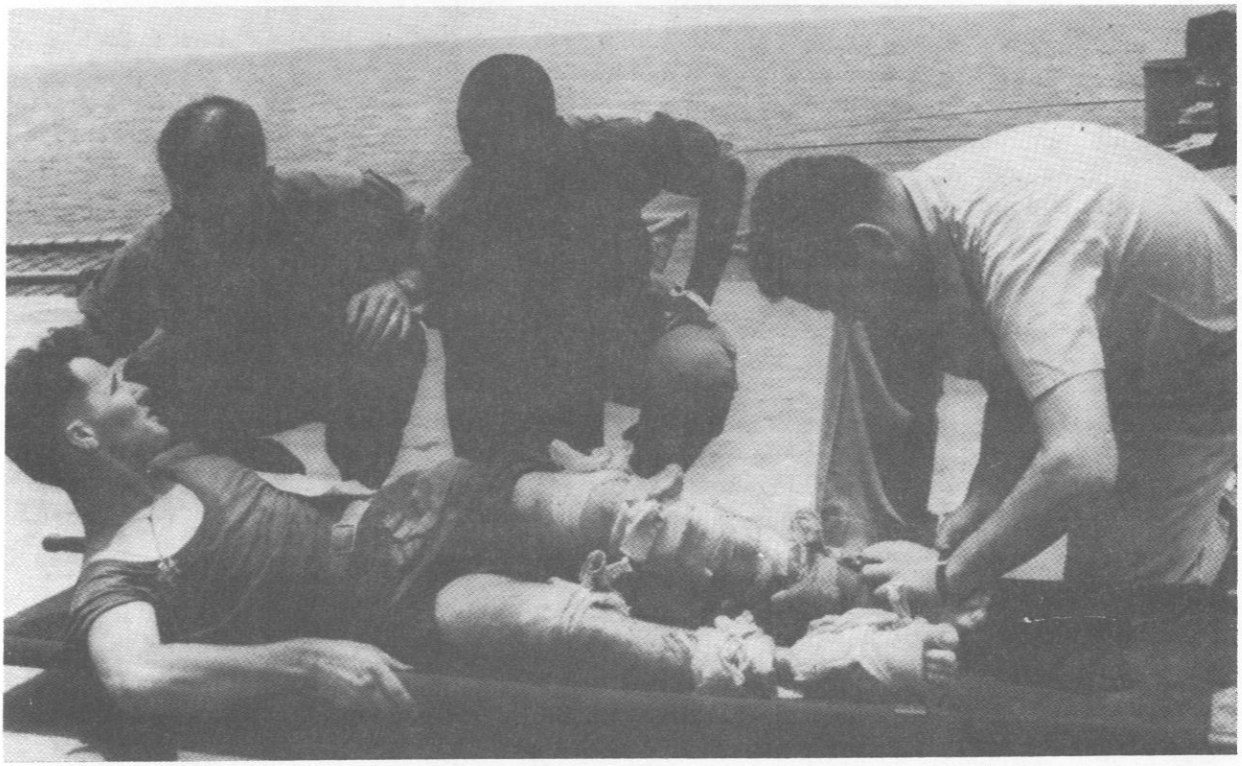
The surgical support team is an organized, ready-reaction group (consisting of a physician, a male nurse, and ten hospital corpsmen) that supplements the Navy surgical team. The team is trained and equipped to provide rapid reinforcement of medical facilities afloat or ashore during amphibious operations, natural disasters, or other situations requiring support. The surgical support teams are designed to provide professional pre- and post-operative nursing care, to establish and operate a simple intensive care unit, and to assist in triage if required.

Designated Surgical Support Team Sponsors

The following hospitals have been designated by BUMED Instruction 6440.1 series to sponsor surgical support teams:

Naval Hospital	Surgical Support Team Number(s)
Bethesda, Maryland	1 and 2
Portsmouth, Virginia	3 and 4
Great Lakes, Illinois	5 and 6
Oakland, California	7 and 8
San Diego, California	9 and 10
Newport, R.I.	11
Memphis, Tennessee	12

Yokosuka, Japan	13
Pensacola, Florida	14
Beaufort, South Carolina	15
Corpus Christi, Texas	16
Orlando, Florida	17
Bremerton, Washington	18
Quantico, Virginia	19
Key West, Florida	20

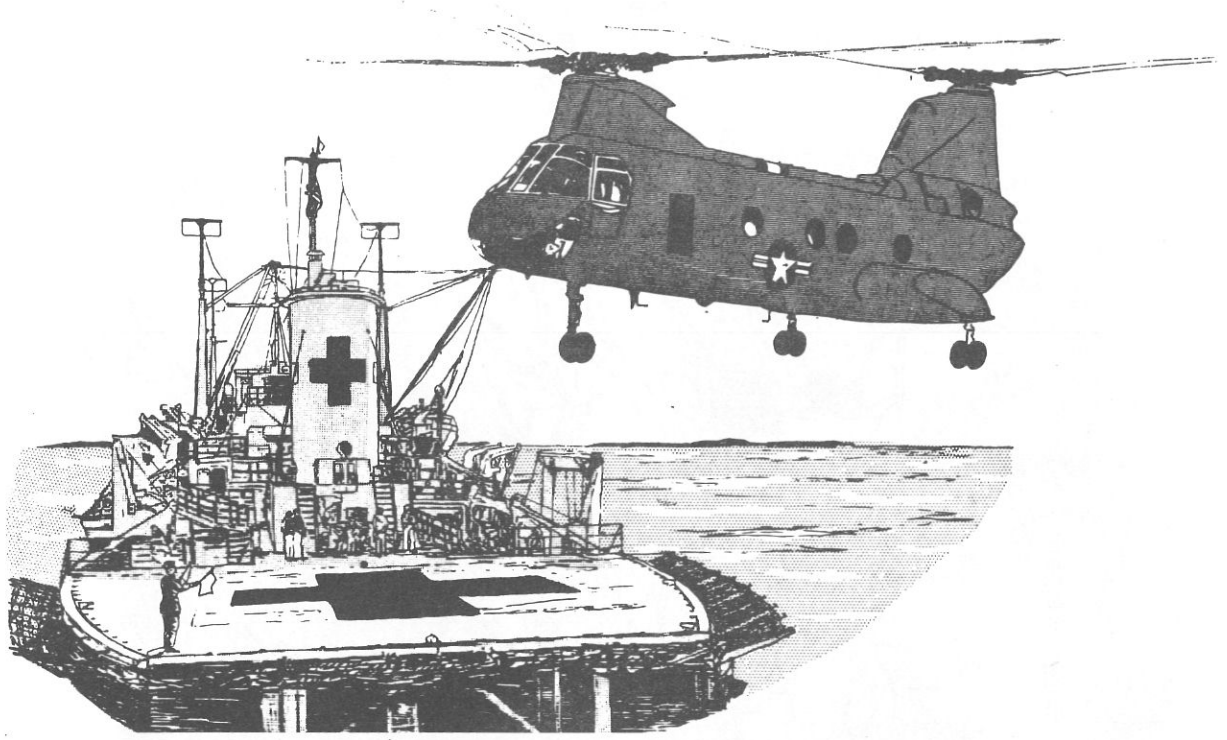


Surgical Support Team Composition

Each of the twenty currently established surgical support teams is composed of the following male members:

1 general medical officer (NOBC 0070) (partially trained surgeon may be substituted)
1 nurse (NOBC 0945) experienced in intensive care
10 general service hospital corpsmen (at least 3 must be trained in intensive care) (HM-0000)

The medical officer-in-charge should have knowledge of, and experience in, medical support in amphibious warfare operations. Although he is primarily employed as a medical specialist, it is desirable that he also possess the strong leadership qualities essential to the efficient operation of the team. The senior hopsital corpsman should be either an HMC or an HMI, preferably with emergency room or field hospital (casualty reception) experience.



Surgical Support Teams in Operation

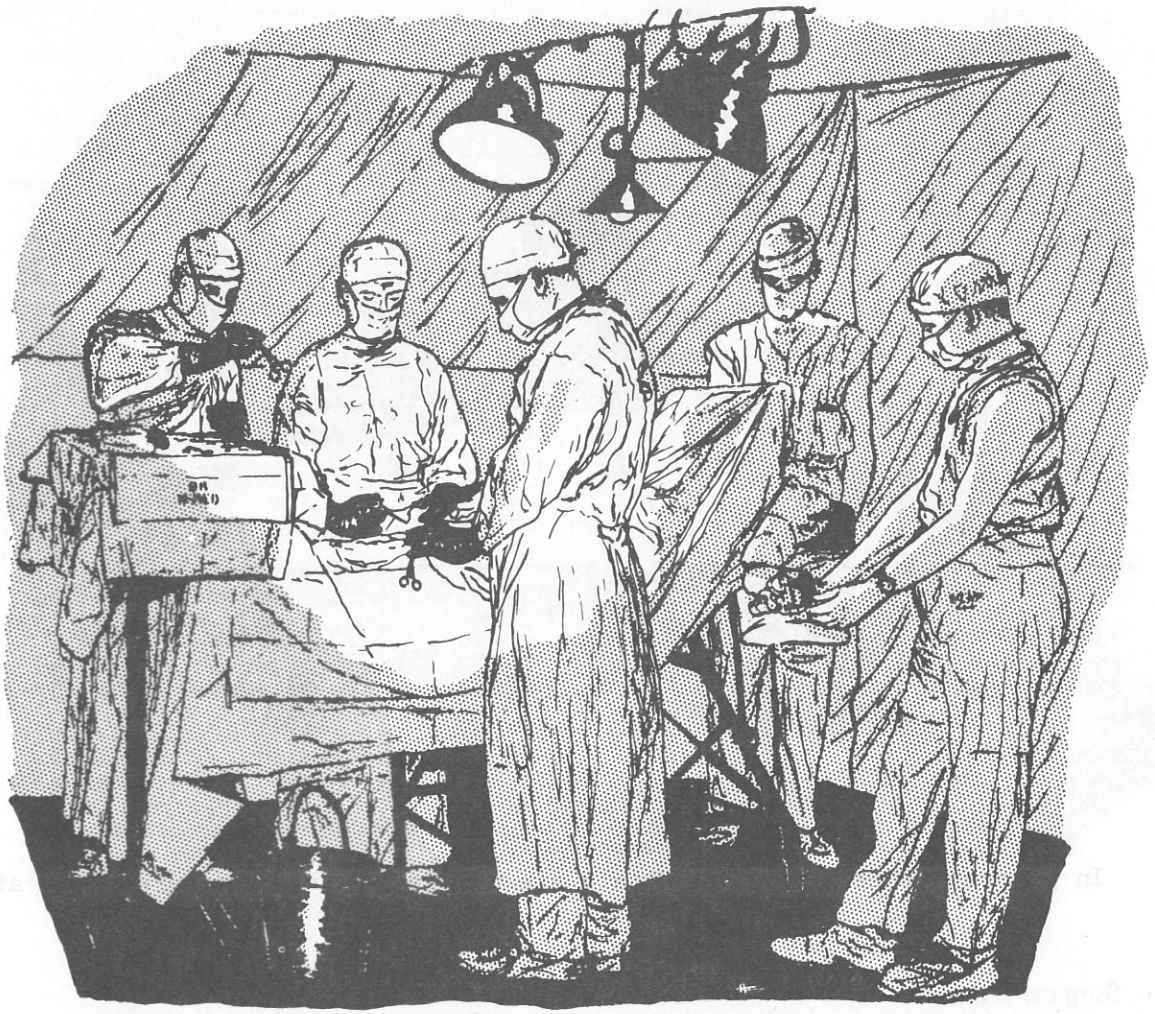
Surgical support teams will normally be used aboard casualty receiving ships. There is a possibility, however, that they could be assigned to shore facilities in unusual situations (disaster relief, etc).

When the patients aboard a casualty receiving ship no longer require the definitive care of a surgical team, the surgical team may be removed and the surgical support team left aboard to augment the ship's company for rendering medical care to casualties enroute to rear area hospitals. Whenever possible, air evacuation will be employed, but situations may arise in which evacuation by ship is the only method available.

When deployed, surgical support teams fall under the same fleet chain of command as do the surgical teams.

Organization of the surgical support team and assignment of individual responsibilities should be accomplished prior to emergency deployment. An alert status system similar to that of the surgical teams is being established. Surgical support team supply blocks are also under development.

Surgical support teams are not capable of self-support or independent operations. Like surgical teams they must be provided full housekeeping support.



FMF SURGICAL PLATOON CADRES

Surgical platoon cadres are organized ready-reaction groups of physicians, male nurses, and enlisted specialists based at major naval hospitals in geographic proximity to major Fleet Marine Force garrisons in the continental United States. Four such teams are organized and trained to serve as the professional cores or cadres of Fleet Marine Force surgical ("clearing") platoons. They are the four designated surgical teams (4, 10, 15, and 19) previously described—each strengthened by the assignment of two additional medical personnel. The number of surgical teams trained and reinforced to act as FMF Surgical Platoon Cadres may vary with the international political climate.

FMF Surgical Platoon Cadre Composition

Surgical teams numbers 4 (NH Portsmouth), 10 (NH San Diego), 15 (NH Camp Lejeune), and 19 (NH Camp Pendleton) are dual-purpose teams and each may be deployed as a navy surgical team or as a surgical platoon cadre. When deployed as an FMF Surgical Platoon Cadre, each will be augmented by:

1 operating room technician (primary or secondary NEC) (HM-8483)
1 pharmacy technician (HM-8482)

Sponsors of teams 15 and 19, in accordance with BUMED Instruction 6440.1 series, will also nominate (to BUMED) one Commander, MC, USN, as a prospective medical ("Collecting and Clearing") company commander. Upon activation of the FMF Surgical Platoon Cadres, the commanding officers of naval hospitals Lejeune/ Pendleton will be notified whether or not this Commander is required for the assigned mission.

When deployed as Surgical Platoon Cadres, teams 4, 10, 15, and 19 will not deploy their surgical team supply blocks unless specifically ordered to do so.

FMF Surgical Platoon Cadre in Operation

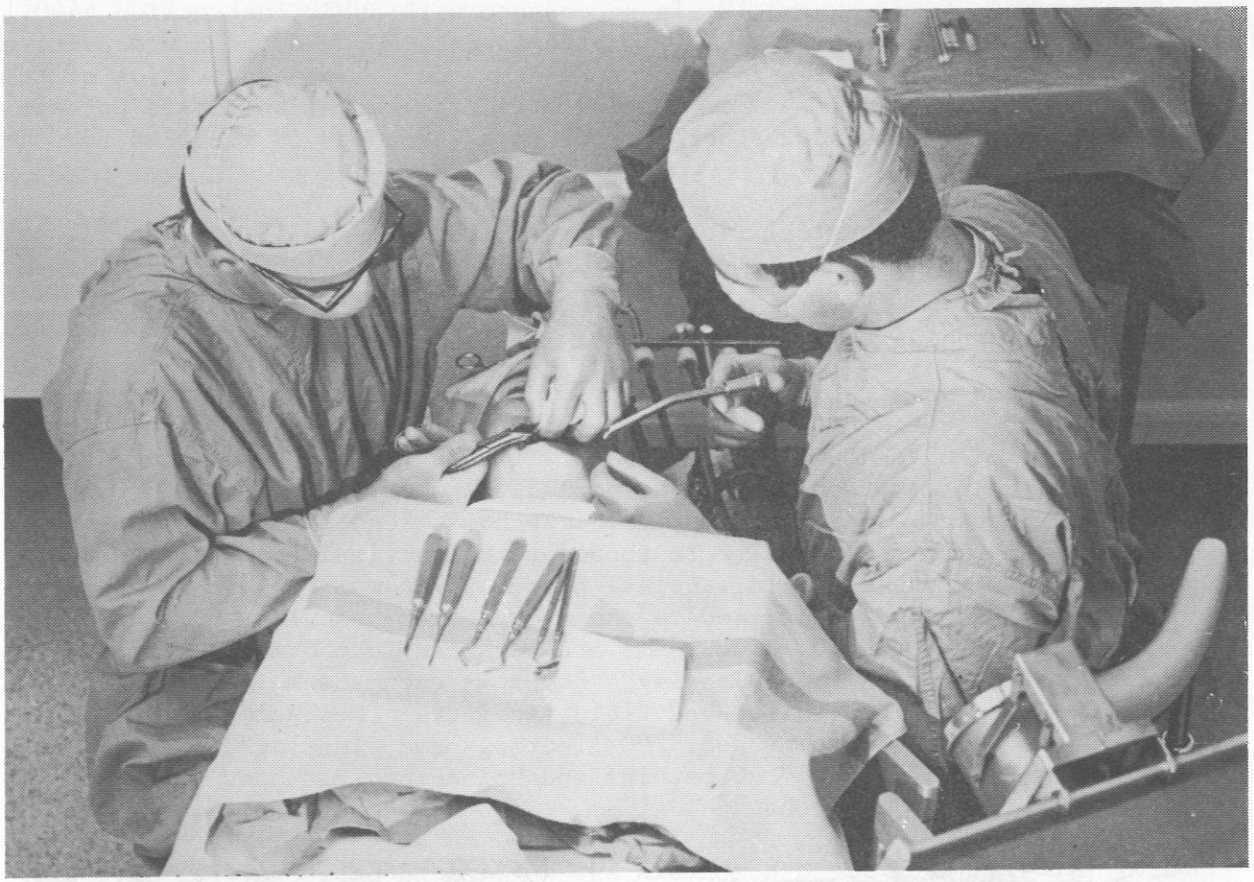
When Surgical Teams 4, 10, 15, or 19 are deployed as Surgical Platoon Cadres with the Fleet Marine Force, they will normally mount out without their surgical supply and equipment blocks and will use the equipment and supplies provided by the unit which they join (normally one of the "Clearing" Platoons of a "Collecting and Clearing" Company). The basic equipment and supplies of these companies are very similar to those of the surgical team. They suffice to establish a sixty-bed field surgical hospital and maintain it in operation for ten days. Personnel assigned to the above teams should study Authorized Medical Allowance List #670. Two teams are required to provide the specialist staff of a "Collecting and Clearing" Company; each team is the cadre of a "Clearing" Platoon with a thirty-bed field facility. (New names for these organizations have been recommended. "Collecting and Clearing" Companies will probably be renamed "Medical" Companies and "Clearing" Platoons will probably be renamed "Surgical" Platoons.)

In general, these field hospitals are not landed until several days after the initial assault. In the interim period, when the casualties may be heaviest, team personnel supplement the medical staffs of the ships of the task force under the direction of the Amphibious Task Force Surgeon (with the concurrence of the Landing Force Commander).

Experiments are now underway to determine the feasibility and desirability of temporarily erecting field hospitals in certain ships which are not normally designated as casualty receiving and treatment ships. If this procedure is adopted teams 4, 10, 15, and 19 might be directed to actually establish a "field hospital" afloat with the equipment and supplies of a "Collecting and Clearing" Company or a "Clearing" Platoon.

For details of organization, procedures, responsibility, resupply, etc., when ashore, team members should consult Fleet Marine Force Manual 4-5, Medical and Dental Support. A three-day orientation course at a Field Medical Service School is recommended before participation in a major exercise for those individuals who have not had field experience.

While the above teams normally deploy without their blocks and use the equipment of the FMF unit, other surgical teams with or without blocks, may be also assigned to reinforce FMF field units. This procedure was employed during several phases of the Korean campaign, and in certain World War II operations.



SPECIAL TEAMS

Special teams are designated to provide reinforcement of medical facilities afloat and/or ashore during amphibious operations, natural disasters, or any other situations requiring surgical support.

Modifications to surgical and surgical support teams in both personnel and equipment are made at BUMED direction to meet specific disaster or operational situations. Other specialty teams may be organized and deployed. The following special teams are under development to provide rapid response to meet specific medical requirements imposed by operational or disaster situations.

Mobile Neurosurgical Team

Oral Surgical Team

Medical Regulating Team

Disaster Relief Team

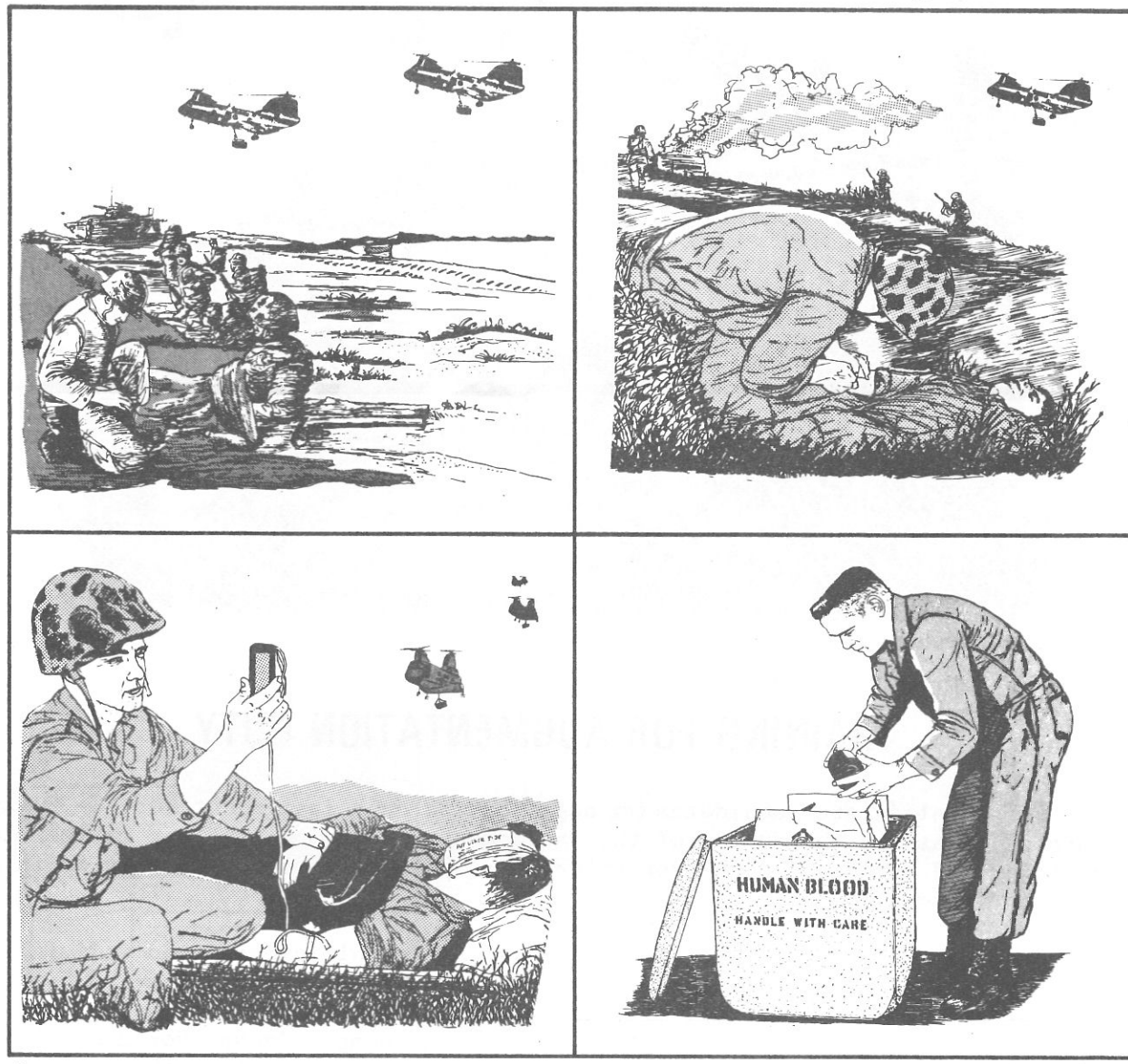
Sponsors of Special Teams

Sponsors of surgical teams 1 through 10 may be directed by BUMED to augment or substitute one Medical Officer, Obstetric (NOBC 0299); and one Medical Officer, Pediatric (NOBC 0701), or other specialists for disaster relief missions.

Special Teams in Operation

Special teams give the specialized medical support services required during various types of amphibious operations and/or natural disasters. They provide health care services for persons in need of obstetric care, pediatric care, neurosurgical or oral/maxillofacial treatment (15% of combat injuries).

Special teams are not capable of self-support or independent operations. The teams must be attached to a medical facility of a landing force unit or ship which can furnish space for an operating room plus laundry, power, heat, sterilizing capability, messing, berthing, and (at least) minimal patient holding and administrative capabilities. In general, special teams will deploy with the instruments/equipment/supplies unique to their mission, but will not be supplied with basic surgical equipment/supplies.



INDIVIDUAL AUGMENTATION ASSIGNMENTS

Individual augmentation personnel are provided by designated activities in accordance with SECNAV Instruction 6440.1 series. The responsibility of

Navy and Marine Corps activities to provide Navy specialist personnel to support the FMF during deployment is based on SECNAV Instruction 6440.1 series. The following chart sets forth the augmentation medical officer billet requirements to bring two Marine Amphibious Forces (MAF's) to Marine Corps Table of Organization strength. The numbers shown vary with the peacetime staffing levels of FMF organizations. Similar tables exist for Dental Corps, Medical Service Corps, Nurse Corps, and Hospital Corpsmen.

TRAINING FOR AUGMENTATION DUTY

Personnel who are candidates for augmentation duty assignment must be fully prepared to assume the duties of the assignment. The augmentee can anticipate demanding and strenuous work over extended periods of time aboard ship or in a field environment.

Augmentation training is that supplemental formal/informal and individual training that enables the augmentee to function effectively in various combat or disaster environments. Formal training is available for FMF augmentees at the Field Medical Service Schools (FMSS), located at Camp Lejeune, North Carolina and Camp Pendleton, California. Personnel are encouraged to attend these courses as part of their augmentation training programs. Amphibious warfare exercises and field medical exercises provide excellent means for testing, evaluating equipment, and training augmentees.

Naval Hospital	POSITION, TYPE OF DUTY, PERSONNEL CODE											
	A*	B	C	D	E	F	G	H	I	J	K	L
Beaufort		1		1	1							
Bethesda		2		1	2							
Camp Lejeune				1	1	1						
Camp Pendleton		2	1	1	3							
Charleston		1		1	1							
Chelsea		1			2							
Corpus Christi					1							
Great Lakes		1		1	1							
Jacksonville		2		1	1							
Memphis		2		1	1							
Oakland		2		1	1		1					
Pensacola		2		1	1							
Philadelphia		1		1	1		1					
Portsmouth, N.H.		1										
Portsmouth, Va.		4		1	1							
St. Albans		2		1	1							
San Diego		3		3	3							
BUMED	40		1	9		3		40	8	2	2	3
TOTAL	40	36	2	16	33	4	2	40	8	2	2	3

* LEGEND

A - Flight Surgeon 2100/0045

B - Surgeon 2100/0214

C - Opthalmologist 2100/0234

D - Ortho Surgeon 2100/0244

E - Anesthesiologist 2100/0613

F - Internist 2100/0637

G - Psychiatrist 2100/0737

H - General Medical 2100/0070

I - Dental G P 2200/0335

J - Oral Surgeon 2200/0550

K - Periodonist 2200/0560

L - Prosthodontist 2200/0569

Source of Medical/Dental Officer Augmentees

Although formal training courses exist to assist the augmentee in becoming prepared for assignment, these training courses cannot provide adequate training for all possible contingencies. It is, therefore, essential that each individual augmentee strive to expand his knowledge of his specialty as it may be applied in combat or emergency conditions, in tropical and cold weather situations.

Officers designated as potential augmentees for the FMF should familiarize themselves with and maintain proficiency with the .45 caliber pistol and should maintain physical fitness.

TEAM TRAINING

The commanding officer of the sponsoring naval hospital is responsible for training surgical teams, surgical support teams, FMF Surgical Platoon Cadres, and other specialized teams as directed by BUMED Instruction 6440.1 series. Training should be provided under close supervision to ensure that each team is well-oriented and completely familiar with its equipment and supplies. Training should be thorough and continuous to ensure capability for rapid deployment in order to provide superior surgical care to combat casualties or disaster victims under adverse conditions.

Training should be performed at each sponsoring hospital with emphasis placed on traumatic surgery. The annual CINCPAC War Surgery Conference Reports (1967-1971) are particularly useful. Surgical team personnel must also maintain familiarity with the contents and functional packing of the material in the surgical team supply block.

Additional training of the surgical team to provide care under seabased and field conditions is encouraged. Commanding officers may request availability periods for such training from BUMED.

Sponsors of surgical teams 4, 10, 15, and 19 should ensure that all team members lacking previous FMF experience attend an indoctrination course at an FMSS. Special three-day courses are available; direct consultation with the Commanding Officer, FMSS, Camp Lejeune, North Carolina or Camp Pendleton, California, is encouraged. Field training with the FMF is especially essential due to changes being made in field medical facilities. The Medical Unit Self-Contained Transportable (MUST) system of shelters and equipment is currently being phased into use in the FMF and will provide an environment far superior to tentage.

Upon the completion of local, field, or shipboard training, the senior member of the surgical team should prepare a written critique of the exercise(s) including any recommendations. As a part of the critique, the senior member should certify the condition of readiness, a list of deficiencies, and a statement indicating action taken or recommended to correct discrepancies. This critique should be submitted to BUMED via the sponsoring hospital commander.

INDIVIDUAL AUGMENTEE TRAINING

The commanding officers of the Navy and Marine Corps activities designated to provide personnel for individual augmentation assignments are directed by

SECNAV Instruction 6440.1 series to be responsible for their training. They must ensure that designated augmentees are prepared and adquately trained for deployment. Augmentee personnel are to be assigned for training to the FMSS at either Camp Lejeune or Camp Pendleton when staffing, time and funds permit.

The keystone of the medical support to the FMF is the staffing of permanently assigned Medical Service Corps officers and enlisted personnel who have been trained in the logistics and operation of FMF medical units. Augmenting personnel should rely on these experienced personnel for guidance in the operation of their units. It is only because of this nucleus of trained personnel with the FMF that the augmentation concept is possible.

REFERENCE MATERIAL

Candidate augmentees are encouraged to become familiar with the reference material related to their assignments. The following list of reference material provides a source of information for augmentees. Naval hospitals are encouraged to assist augmentees in obtaining copies of references particularly suited to their requirements.

NAVY INSTRUCTIONS AND PUBLICATIONS

SECNAVINST 6440.1 series	Navy Support of the Fleet Marine Force
BUPERSINST 6100.2 series	Physical Fitness
BUMEDINST 6230.1 series	Immunizations Requirements and Procedures
BUMEDINST 6230.11 series	Malaria: Control and Prevention
BUMEDINST 6320.1 series	Medical Regulating to and within the Continental United States
BUMEDINST 6440.1 series	Surgical Teams, Surgical Support Teams, FMF Surgical Platoon Cadres, and Other Special Teams for Combat and Disaster Emergency Medical Support
BUMEDINST 6530.1 series	Navy Blood Program
NAVMED P-117 series	Manual of the Medical Department
NAVMED P-5010 series	Manual of Naval Preventive Medicine
NAVMED P-5016 series	Handling of Deceased Personnel in Theatres of Operations
NAVMED P-5041 series	Treatment of Chemical Warfare Casualties
NAVMED P-5047 series	Medical Support of Joint Operations
NAVMED P-5059 series	Emergency War Surgery Handbook (NATO)
NAVPERS 10816 series	Medical Department Orientation

NAVPERS 10817	Combat and Field Medicine Practices
NWP-30	Amphibious Operations
NWIP 22-3(c)	Ship to Shore Movement

FLEET MARINE FORCE MANUALS

FMFM 4-1	Logistic and Personnel Support
FMFM 4-3	Shore Party Helicopter Support Teams Operations
FMFM 4-5	Medical and Dental Support
MCO 6300.1 series	Heat Casualties
MCO 6600.1 series	Fleet Marine Force Dental Service; Policies and Doctrines Concerning

MISCELLANEOUS INFORMATION SOURCES

Federal Supply Catalog, Department of the Defense Section, Medical Materiel Catalogs, Washington, D.C.; Department of Defense; 1961

CINCPAC Conferences on War Surgery, Volume 1-5

Manual of Tropical Medicine, Geo. Wm. Hunter III et al. 4th edition, W. B. Saunders Co., Philadelphia, Pennsylvania; 1966

Medical Capability Survey and Inventory of the Ships of the Amphibious Force, U.S. Atlantic Fleet of October 1970 (and companion PACFLT volume when available)

Status of World Health, U.S. Government Printing Office

Symposium "Management of Mass Casualties", published by Medical Service School, Brooke Army Medical Center, Fort Sam Houston, Texas

The publication FMFM 4-5, "Medical and Dental Support", is of particular significance to FMF augmentees; it presents doctrine, procedures and techniques concerning the organization, command relationships, planning considerations, and the employment of medical and dental units in the support of the Fleet Marine Force operations. It describes the organization, plans, and operations of medical and dental service within the landing force and the amphibious task force during all phases of the amphibious operation. Casualty evacuation, records, and reports during the assault stage are described. Medical and dental training and supply procedures are outlined. It is available in the libraries of all naval hospitals.

CORRESPONDENCE COURSES

In addition to formal training, unit training, and individual on-the-job training, various correspondence courses are available to expand individual knowledge related to augmentation assignments. These courses are available from

the Naval Medical School. One of the courses offered which should prove beneficial to the augmentee is "Combat and Field Medicine Practice", NAVTRA 10706-B.

TRAINING FILMS

Training films related to medical support afloat and ashore are available. They are especially useful in the development of unit training programs. NAVMED P-5042, 1970 and NAVMED School Medical Film Catalog, 1972 are film reference guides for medicine and allied sciences. They list films available for loan from the following agencies:

Department of the Army--Office of the Surgeon General
Department of the Navy--Bureau of Medicine and Surgery
Department of the Air Force--Office of the Surgeon General
Armed Forces Institute of Pathology
Department of Health, Education, and Welfare--National Library of Medicine
Veterans Administration--Department of Medicine and Surgery

Some of the films which should be of special interest to augmentees are:

"The Surgical Team in Amphibious Support" (MN-10488)
"Medical Support in a Marine Expeditionary Force" (MN-9513A)
"Medical Support in a Marine Amphibious Assault: The General and Special Situation" (MN-9513B)
"Medical Support in a Marine Amphibious Assault: The Medical Plan" (MN-9513C)
"Medical Support in a Marine Amphibious Assault: Conduct of the Landing" (MN-9513D)
"The Medical Officer Aboard Ship" (MN-8265)
"Medical Planning for a Task Force Operation" (TF8-1761)
"Medical Service in the Jungle" (FB 8-147)
"Medicine Hits the Beach" (MN-3732)

AMPHIBIOUS OPERATIONS AND FORCES

Amphibious operations involve the assembly of an assault force, transit to the area of operation, and movement ashore. The assault itself may be mounted by air (helicopters) or surface (landing craft) or a combination of the two, which is the usual case. Marine operations are normally planned to be of short duration; a coastal objective is seized and defended until regular Army troops can arrive to expand the beachhead and conduct extended land warfare. In some cases the Marines may be required to remain and participate as ground troops in an extended operation. This requires special support arrangements, since the Marines are essentially light assault forces and lack the back-up logistical organization required for extended operations.

Task forces for amphibious operations are temporary organizations "tailor-made" for each operation from existing organizational units. They vary in size, but are normally built around a ground element which may be a battalion (about 1000 men), a regiment (about 3500 men) or a division (about 17,500 men). The amphibious task force, of whatever size, consists of three principal elements:

the amphibious force (i.e., the ships), the landing force, and the support force. The landing force is normally an air/ground team; the helicopters used to land the ground troops are part of the landing force and can move their base of operations from the ships to airfields ashore. Tactical and service air support may also be phased ashore. The third element, the support force, consists of ships to furnish naval gunfire, aircraft carriers, antisubmarine units, minesweeps, etc., and will not be further discussed since none of these ships are normally used for casualty receiving and treatment.

TASK FORCE TERMINOLOGY

Amphibious Task Unit/Marine Amphibious Unit (ATU/MAU)

This is the smallest basic force. It consists of 5 to 7 ships (an amphibious squadron or PHILBRON), a battalion of ground troops with attachments and deletions (battalion landing team or BLT), and 20 to 30 helicopters of various sizes (a Provisional Marine Air Group or PROVMAG). The ships comprise the Amphibious Task Unit (ATU); the troops and the aircraft are the Marine Amphibious Unit (MAU). (The ATU/MAU has also been known as an "Amphibious Ready Group/Special Landing Force" or ARG/SLF.) Several ATU/MAU's are continuously afloat in troubled areas such as the Mediterranean and Western Pacific. Others may be formed and deployed intermittently to areas such as the Caribbean and Indian Ocean. This task force is designed for small scale combat, protection of U.S. Nationals and property in areas of civil unrest, disaster relief operations, and similar tasks. One or two medical officers and 40 to 65 corpsmen are included in the Marine battalion. In addition, the necessary equipment and supplies may be carried to establish a thirty-bed emergency shore hospital and in some cases a skeleton crew for this may be carried. A medical officer and 8 to 10 corpsmen are normally assigned to a helicopter carrier (Amphibious Assault Ship--LPH), normally the principal ship of such a Task Force. If a casualty care situation appears likely, a surgical team and surgical support team would be assigned to the helicopter carrier to establish a surgical capability afloat. Casualties would be evacuated to the ship by helicopter.

If it becomes desirable to establish a small field hospital ashore a Surgical Platoon Cadre could be airlifted to the site to use the thirty-bed hospital ("clearing station") mentioned above. Alternatively, the embarked surgical team could be used to staff this hospital ashore. Although the capability to establish field hospitals of this small size in support of independent battalions has existed for many years it has very rarely been employed in combat operations.

Command and control of the operation is initially exercised from the helicopter carrier but may be moved ashore.

Amphibious Task Group/Marine Amphibious Brigade (ATG/MAB)

This is the middle-size task force. It is approximately three times as large as the ATU/MAU and consists of 15 to 20 ships (an Amphibious Group or PHIBRU), a Regimental Landing Team (RLT) of Marines, and about 50 helicopters. The communications circuits available on a helicopter carrier are not sufficient to control the assault operations of a task force of this size so a special ship, the Amphibious Control Ship (LCC), is included in the force. The LCC is not normally used as a casualty receiving ship but the Medical Regulating Center

(MRC), that controls casualty distribution to the ships of the task force, plus the Amphibious Force Surgeon and the Landing Force Surgeon, are normally located aboard the LCC.

This task force is capable of engaging in combat of greater magnitude and intensity than the ATU/MAU and so the proportion of medical support personnel is usually increased. In addition to the medical personnel of the regiment and air group, a medical company ("Collecting and Clearing" Company) will usually be attached. This company is equipped to erect a sixty-bed field surgical hospital. The staff consists of corpsmen and Marine personnel from garrison forces plus two FMF Surgical Platoon Cadres deployed from naval hospitals. If helicopter operations are unopposed and casualties can be returned to the ships promptly, the company may not be established ashore. In any event, the doctors and corpsmen would normally work in the shipboard operating rooms for the first several days of the operation, until sufficient security is established ashore to permit field hospital operations.

In addition to the medical company of the landing force, the ATG Surgeon would probably employ three or more surgical teams and an equal number of surgical support teams to establish a surgical capability on various ships of the ATG. The number of ships to be so staffed and designated as "Casualty Receiving and Treatment Ships" would depend upon the casualty estimates. Rapid provision of additional teams and equipment could be accomplished through further use of the augmentation plan.

Amphibious Task Force/Marine Amphibious Force (ATF/MAF)

This is the largest regularly organized amphibious task force. The ATF/MAF consists of 44 to 55 amphibious ships, a Marine Division (reinforced) of ground forces, and a Marine Aircraft Wing. The Wing includes fixed wing aircraft squadrons and helicopter squadrons. The Marine Division (reinforced) includes about 15,000 assault troops and an almost equal number of support and service troops--i.e., artillery, engineers, tanks, medical, supply, etc. Some of these troops, and some parts of the air component, would not move ashore until 3 to 5 days after the initial assault. Medical support essential for a landing force this size against a defended objective would normally include a hospital ship and surgical and surgical support teams on each of the helicopter carriers and on various other ships of the amphibious force. The division "Medical Battalion", consisting of a Headquarters and Service Company and four "Collecting and Clearing" companies, would provide the equivalent of eight surgical teams to staff shipboard surgical facilities during the assault phase. As secure areas were established ashore, these companies would be moved ashore where they would be employed individually (to set up sixty-bed surgical hospitals) or combined to form larger hospitals. Other field hospital facilities may be attached to the MAF if required.

OPERATIONAL CONCEPTS

In classic amphibious operations, during the assault phase the landing force receives total support from the ships at sea. Initial supplies of all

sorts are off-loaded in priority sequence. After a beachhead has been secured, general unloading commences and all supplies are unloaded as rapidly as possible and delivered to dumps ashore. Individual combat units draw from these dumps.

During the early phases of the assault little more than first aid from Navy doctors and corpsmen attached to the Marine units is available ashore. Casualties sustained during the first two or three days of the operation are furnished definitive care aboard ship. Field surgical facilities are moved ashore as soon as the tactical situation permits and initial definitive treatment is gradually phased ashore. However, it should be remembered that Marine organizations do not have sufficient medical assets to become totally self-sufficient. Supplemental medical/surgical support from the fleet or other attached medical facilities such as advance base hospitals is explicitly assumed.

Command and control of the landing force moves ashore as soon as the troop commander feels he can more effectively control the landing force from there and when sufficient personnel, equipment, and supplies have been established ashore to accomplish this.

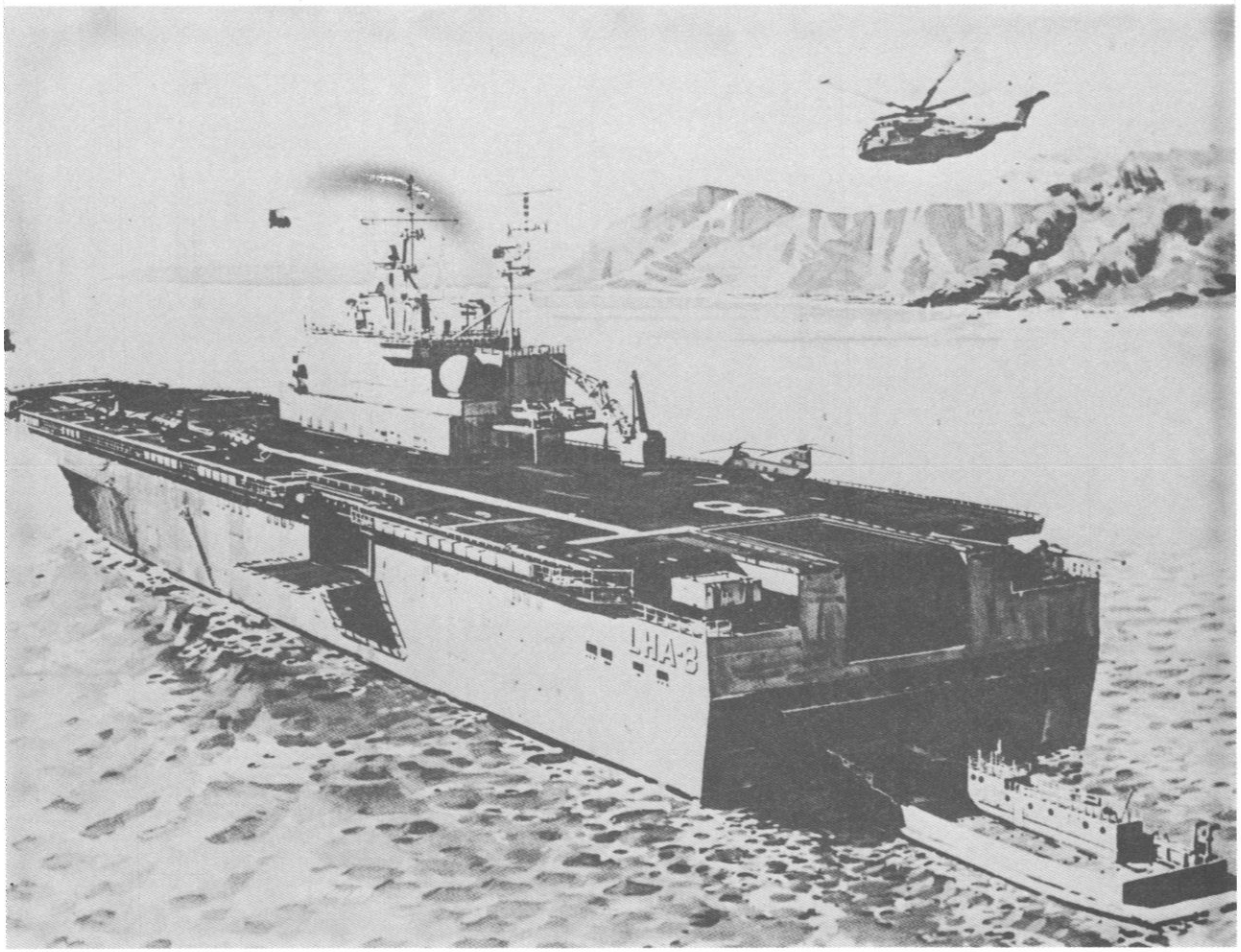
New concepts of amphibious warfare including the Seaborne Mobile Logistics Concept and the Sea-basing Concept of operation are currently being tested and evaluated for task forces of ATU/MAU and ATG/MAB size. These concepts are possible due to the increasing availability and effectiveness of helicopters, the communications system, and the anticipated combat environment in which they will be employed. Tests of these concepts in operational exercises of various sizes will become increasingly frequent. Both concepts contain the provision that the ability be maintained to move command/control, and service support ashore, if required. The same is true of medical support. All definitive care will normally be provided aboard ship; however, the medical personnel and equipment of the landing force must be capable of displacement ashore if necessary. A general description of the two concepts follow.

The Seaborne Mobile Logistics Concept provides that all logistic functions (supply, maintenance, medical, etc.) will remain afloat during amphibious warfare operation. Other headquarters functions, including command and control organizations phase ashore. Supply dumps are not established ashore. Unit resupply is made by helicopter directly from the ships of the task force. In this concept all patients requiring definitive medical treatment are returned to the ships.

The Sea-Basing Concept provides that both logistic support and the landing force headquarters staff (command and control) remain afloat. The operation is totally controlled and supplied from afloat.

SHIPS OF THE AMPHIBIOUS FORCES

The Amphibious Forces of the U.S. Fleet consist of about 80 ships. They are new, fast (20 knots plus), and all have helicopter landing platforms. The following ships are representative examples of the principal amphibious types. For detailed medical space plans and other information see "Medical Capability and Inventory of the Ships of the Amphibious Force, U.S. Atlantic Fleet".

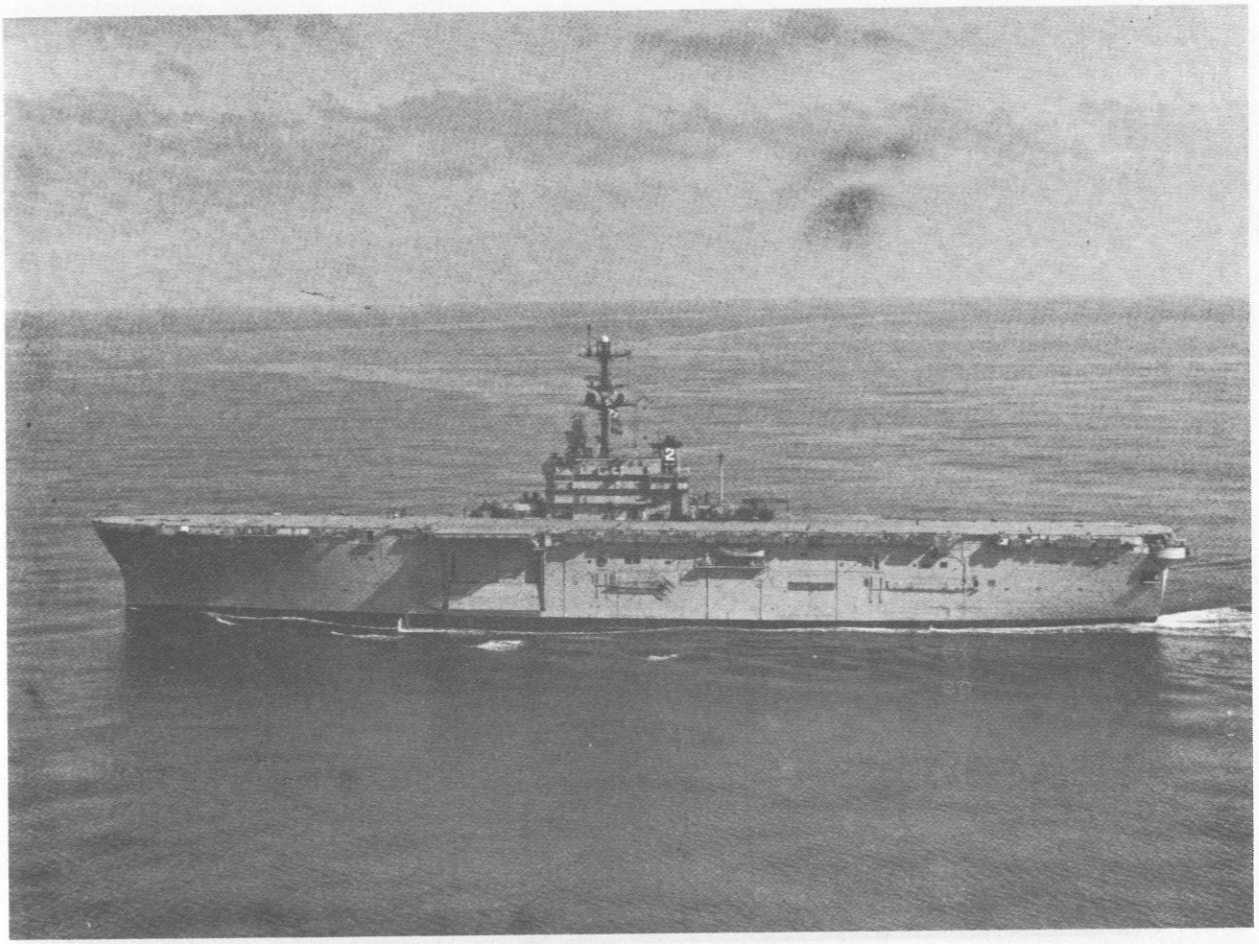


(Artist's Concept)
LHA AMPHIBIOUS ASSAULT SHIP, GENERAL PURPOSE
(five under construction, 1972)

The LHA is a large ship which externally resembles an aircraft carrier. The LHA can transport most of the elements of a Marine Amphibious Unit (i.e. about 1500 assault troops) plus the helicopters, boats, and amphibious vehicles required to land them by air or sea.

Its designed medical spaces are large and include four major and two minor operating rooms, sixty primary hospital beds (including an intensive care area) and a 240-bed, specially-configured overflow ward.

Dental spaces include one oral surgery operating room, two general dental operating, rooms, and supportive diagnostic, patient management, and treatment facilities.

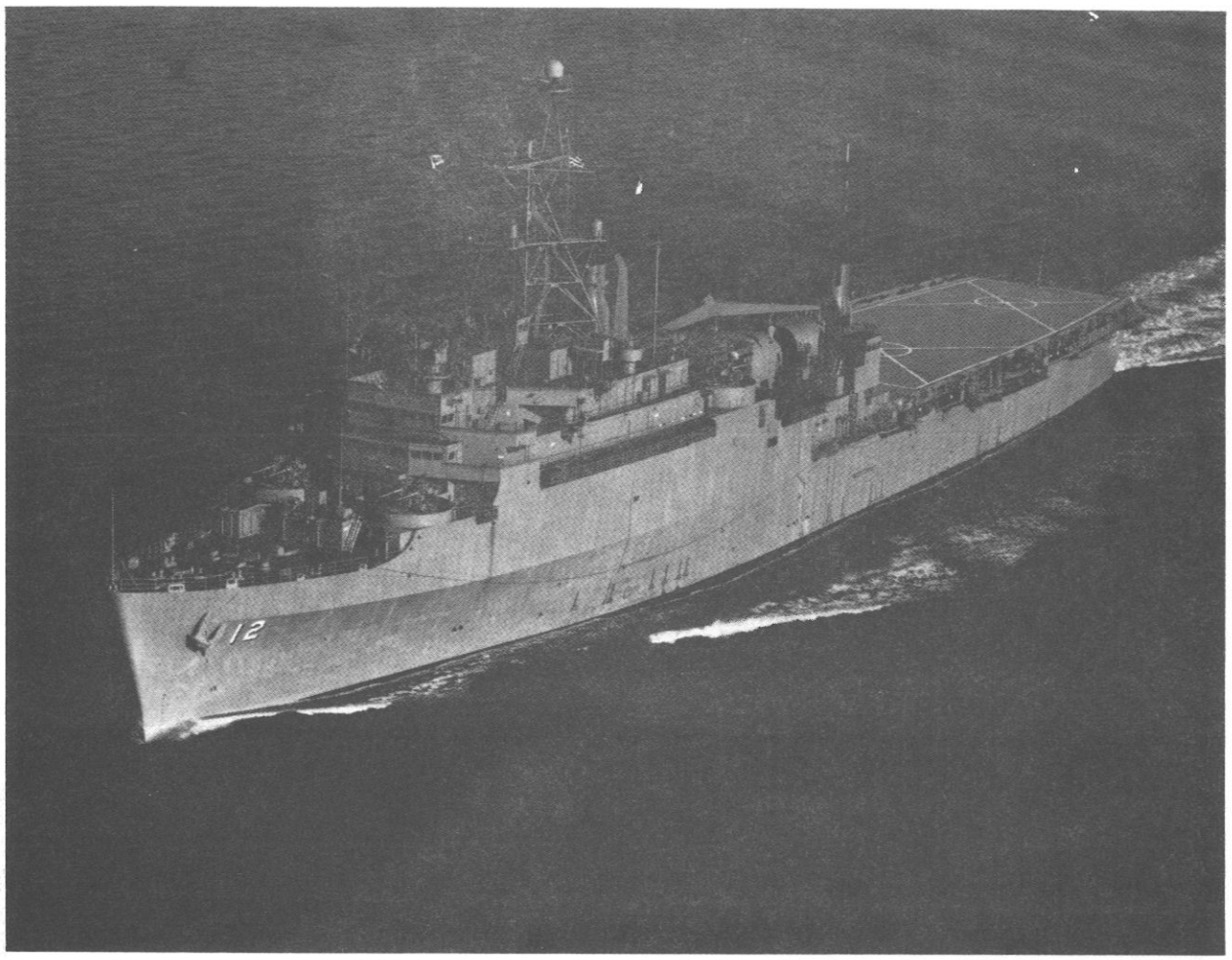


LPH AMPHIBIOUS ASSAULT SHIP

The LPH is also a large ship and is designed to combat-load, transport, and land a Battalion Landing Team (BLT) and a transport helicopter squadron with their essential air transportable equipment and supplies. To accomplish this it uses the embarked assault transport helicopters of the landing force. If the force is to be landed by surface, boats and amphibious vehicles are provided from other ships of the Task Force.

Medical spaces of the LPH consist of two or three surgical operating rooms, two dental operating rooms and supporting casualty care facilities. The dental spaces provide operating rooms for oral/maxillofacial surgery as well as for emergency dental care in general.

Diagrams of typical LPH medical spaces and the principal items of equipment which they contain may be found in "Medical Capability Survey and Inventory of the Ships of the Amphibious Force, U. S. Atlantic Fleet." Copies of this document are available in the library of each of the naval hospitals.



LPD AMPHIBIOUS TRANSPORT, DOCK

The LPD is used to embark, transport, and load elements of a landing force and essential equipment and supplies by means of embarked landing craft or amphibious vehicles, augmented by a limited helicopter lift.

The LPD is characterized by a well deck which can be flooded and a stern gate so that landing craft can dock within the ship itself. This greatly facilitates loading operations. The LPD can carry 900 to 1000 troops.

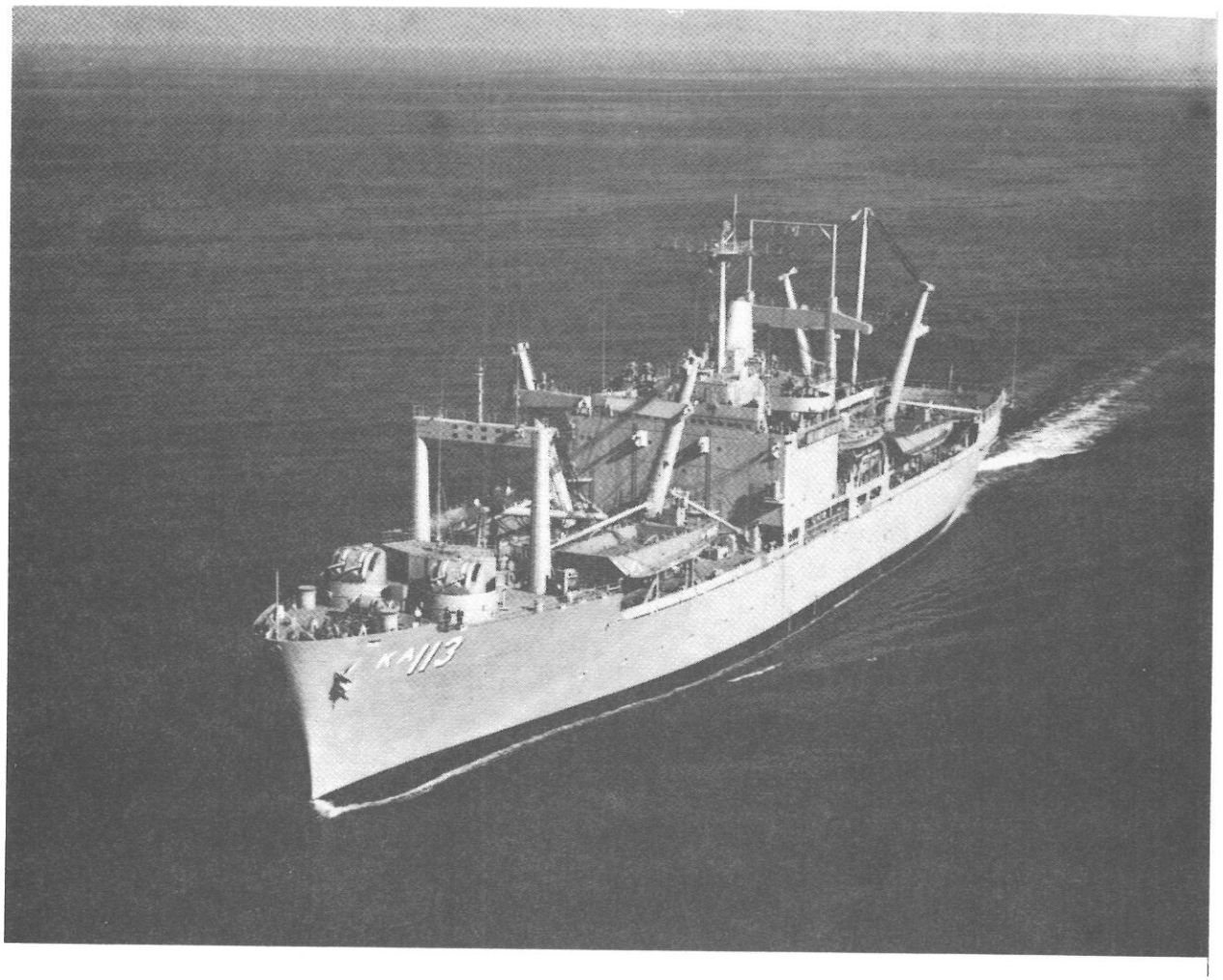
Its current (1972) medical spaces are not considered adequate to allow the ship to support a surgical team. Proposals to modify and expand the medical/dental facilities are under consideration.

LSD DOCK LANDING SHIP

Although called a "landing ship" the LSD does not beach. The LSD is similar to the LPD except that its well deck is larger with greater capacity, thereby diminishing its troop- and cargo-carrying capability.

The main function of the LSD is to serve as "mother ship" for landing craft and amphibious vehicles. It transports them to the combat area and repairs and maintains them during the operation.

The newer LSD's (LSD 36 et seq.) have much larger medical spaces than the older LSD's and could probably support a surgical team and serve as secondary casualty receiving and treatment ships. Studies are being conducted of the feasibility of using this type ship as a platform for a field hospital.

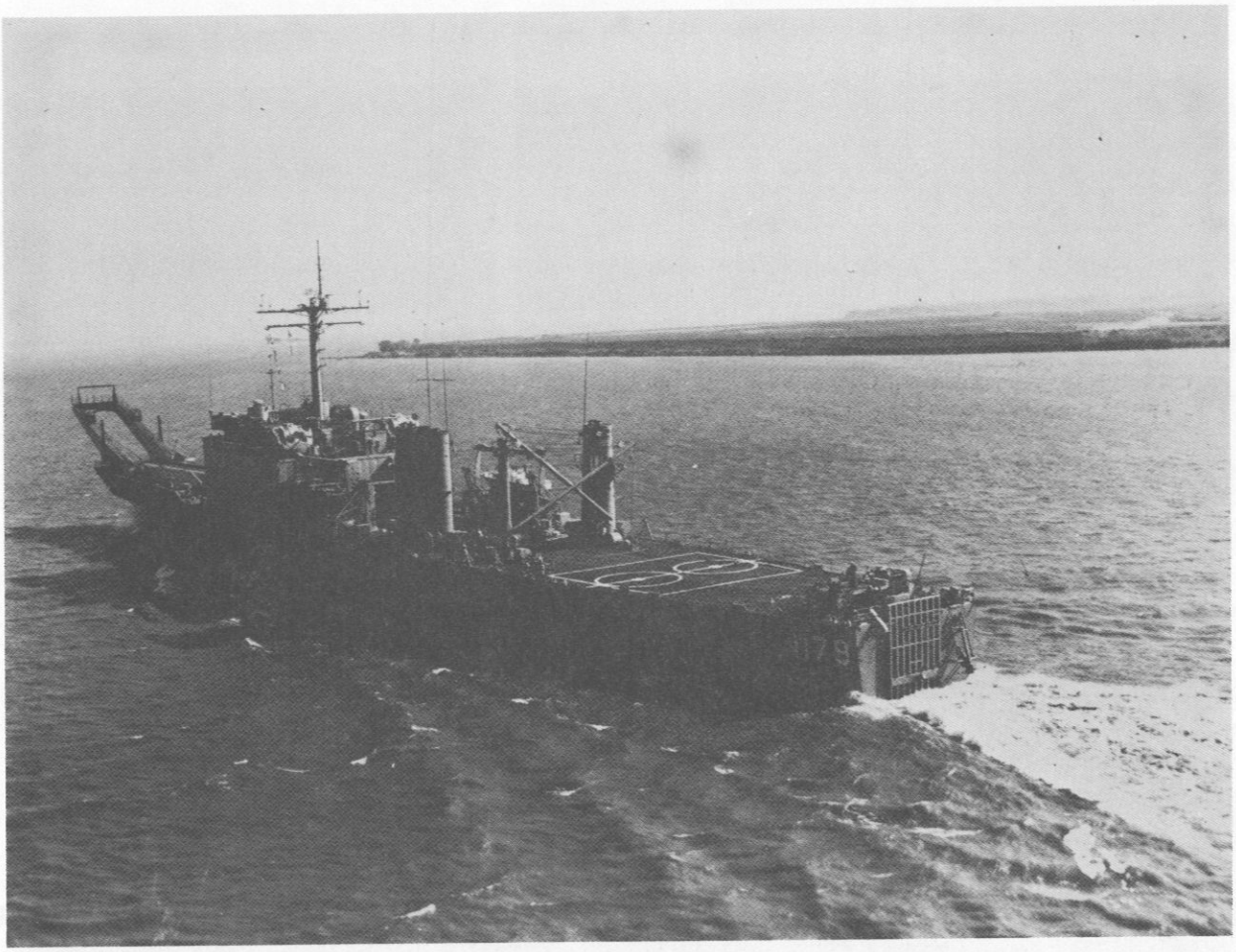


LKA AMPHIBIOUS CARGO SHIP

The LKA is used to transport supplies and equipment plus a limited number of troops to the objective area.

The newer LKA's have a helicopter platform but most supplies and equipment they carry is moved ashore by landing craft belonging to the ship.

Newer ships (LKA-113 class) have medical spaces which include two surgical operating rooms. These ships have considerable potential to serve as casualty receiving ships and there is an active program to accomplish certain ship alterations to realize this potential.

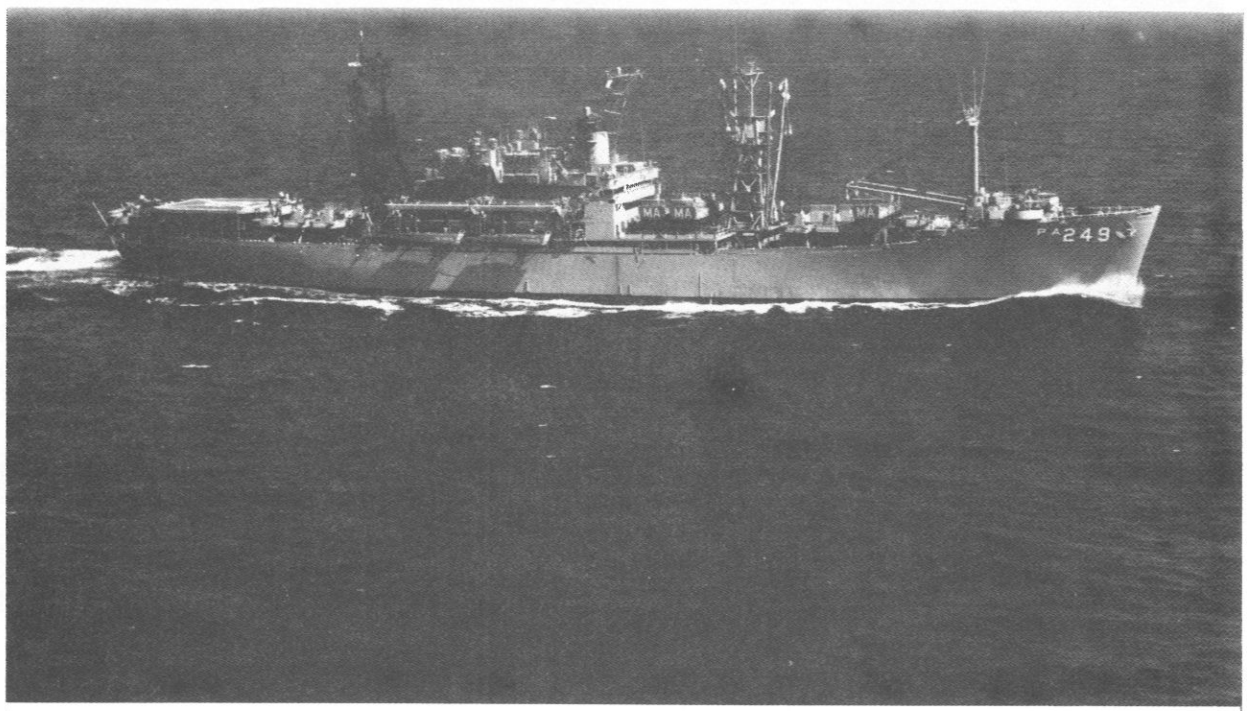


LST TANK LANDING SHIP

LST's vary significantly depending upon the class of ship. The earlier LST's have "clam shell" bows which open and allow unloading of vehicles and supplies directly onto a beach. The newer LST's (LST 1179 class) are fast ships with much deeper draft and cannot be beached as close to the waterline as the older ones. They have a bow ramp (in lieu of the clam shell bow) that is placed ashore or on a pontoon causeway carried by the ship.

Medical facilities on all LST's regardless of class, are very limited; however, the large tank deck (the deck on which armored vehicles (tanks) and trucks are carried) is suited for use as space for establishing casualty care facilities. Use of LST space in this manner provides a highly mobile facility with good protection from small arms fire, low velocity fragments, and inclement weather. The practice was widely employed in World War II amphibious operations.

The newer LST's are capable of receiving casualties by boat (they have a stern gate), helicopter, or directly from shore via ambulance or hand carry when the bow ramp is extended.



LPA AMPHIBIOUS TRANSPORT

There are only a few LPA's remaining in the Fleet and they are being rapidly phased out.

The LPA has the medical facilities to function as a casualty receiving ship, but helicopter landing capability is marginal and night helicopter operations are hazardous and not normally permitted.

Dental care facilities are available.

LCC AMPHIBIOUS COMMAND SHIP

The LCC is a large ship especially equipped for control of amphibious landings, including medical control of patient movement, etc.

Although it possesses excellent medical and dental facilities, its tactical commitment will not normally allow it to function as a casualty receiving ship. However, it does serve as the medical nerve center of an amphibious operation.

The senior medical officers of the Task Force and the Landing Force and their staffs coordinate all medical activities from this ship. The central medical regulating office (casualty movement control) is also located aboard the LCC.

THE FLEET MARINE FORCE
The Marine Division

A Marine Division consists of three infantry regiments, (each consisting of three infantry battalions) an artillery regiment and seven separate battalions (see the following chart). Its approximate strength is 17,500 men including medical personnel. Medical personnel of the division are under the direct command of the unit to which they are assigned. The following chart, "Organization of the Marine Division," presents the individual subordinate organizations, their approximate strength, and the number of officer and enlisted medical personnel included in each organization.

The Marine Division is commanded by a Major General. He is assisted in various specialized functions by his special staff. The medical special staff officer is the Division Surgeon. The Division Surgeon is assisted by a Medical Service Corps officer and five enlisted personnel. His assigned task is to advise the Division Commander regarding medical matters within the Division.

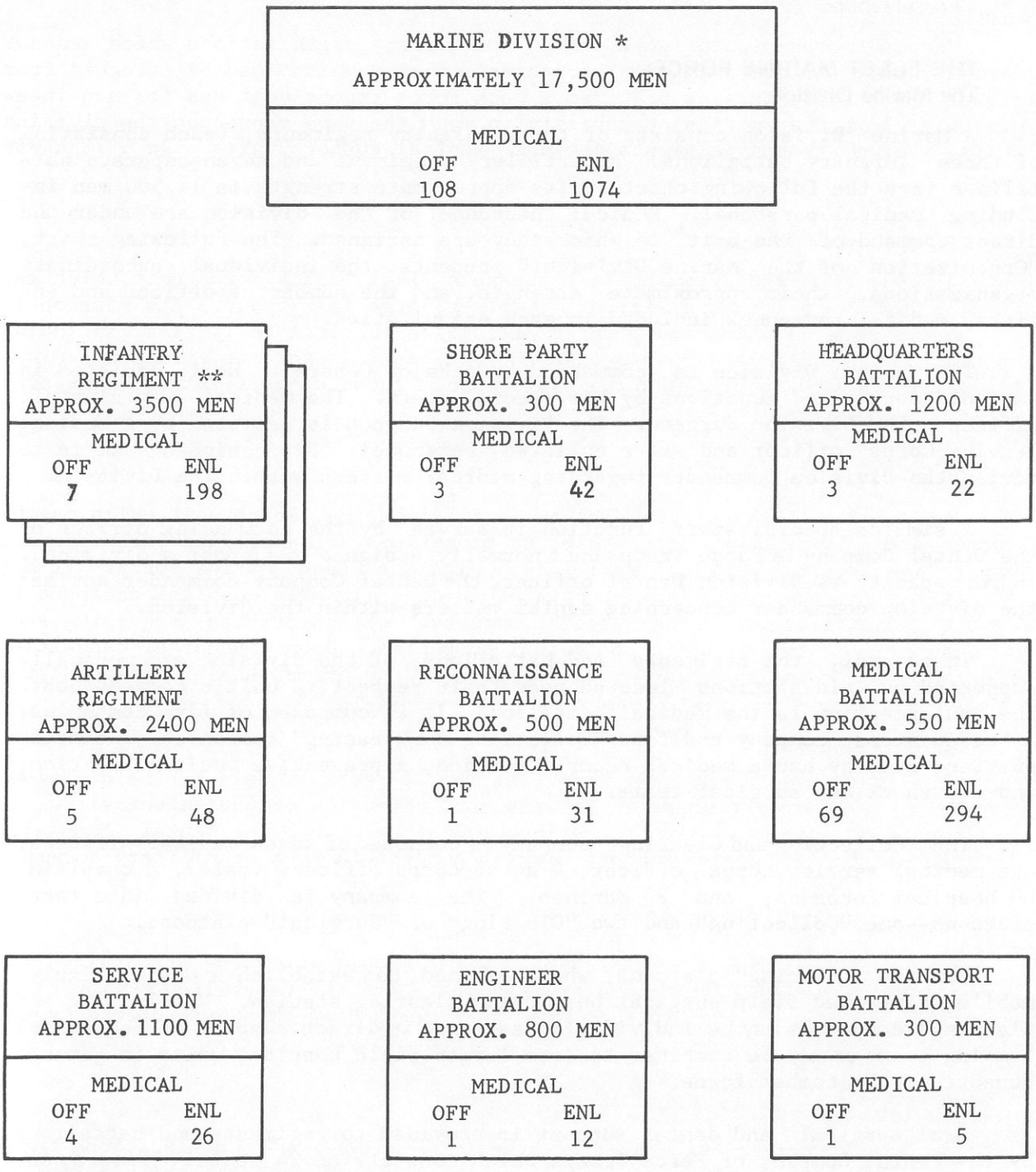
A similar special staff function is served by the commanding officer of the Dental Company (a Force Troops unit normally assigned to support a division). In his capacity as Division Dental officer, the Dental Company commander advises the division commander concerning dental matters within the division.

In general, the regiments and battalions of the division are medically supported by aid stations located near their respective unit's command post. The one exception is the medical battalion. It is composed of five companies: a headquarters company and four "Collecting and Clearing" companies. The headquarters company has a medical records section, a preventive medicine section, and two shock and surgical teams.

The "Collecting and Clearing" company is composed of seven medical officers, one medical service corps officer, 4 nurse corps officers (male), a chaplain, 60 hospital corpsmen, and 25 Marines. The company is divided into three platoons--one "Collecting" and two "Clearing" or "Surgical" platoons.

The two "Clearing" platoons, when combined, can establish a basic, highly-mobile, sixty-bed field surgical hospital or clearing station. "Collecting and Clearing" companies may be individually assigned in direct support of regimental landing teams or may be combined to form larger field hospital units in general support of the combat force.

Oral surgical and dental support is provided to regiments and battalions by the Dental Company of Force Troops which consists of 24 dental officers, one Medical Service Corps Officer and 42 dental technicians. The company is organized into an H&S platoon, a mobile dental clinic section, a clinic platoon, and a prosthetic platoon.



* Unit strength is approximate total strength (including medical personnel) and is subject to frequent minor fluctuations.

** There are three infantry regiments of equal size in a Marine Division.

ORGANIZATION OF THE MARINE DIVISION

Force Troops

"Force troops" comprise a number of support organizations which are not normally part of the division organization, but which can be attached from higher FMF headquarters as required. Each force troops unit has its own integral (but limited) medical capability in much the same manner as the division units. Force troops elements include medical support units. In 1972 these were:

Force Hospital Company

A Force Hospital Company is a separate Fleet Marine Force unit which may be attached to a force, division, or other large task group. Its mission is to provide resuscitation and primary definitive surgical facilities, including facilities for the establishment of a 100-bed hospital for the relatively minor wounded, sick and injured, and the evacuation of those casualties requiring prolonged hospitalization.

Separate Surgical Company

A Separate Surgical Company is a Fleet Marine Force unit which may be attached to a large force for amphibious operations. Its mission is to provide highly specialized surgical facilities within a Fleet Marine Force. It has facilities for the establishment of a 400-bed, semimobile hospital equipped to handle casualties requiring special surgery. All casualties requiring such surgery are routed to it from medical companies. Upon discharge, casualties are returned to their units, or are entered in the normal chain of evacuation.

Dental Company

The force dental company provides dental support to a Marine division, aircraft wing, force troops, or groupings of FMF units of equivalent size. It may function either as a unit or in combination with other dental companies to mass appropriate dental support within a geographic area or military command.

The Marine Aircraft Wing

The Marine Air Wing consists of several groups which are often sited independently. Marine fixed-wing air groups have the capability to establish twenty-bed basic medical/surgical facilities, as does the Headquarters Group. Helicopter Groups do not have a surgical capability.

Future Developments

As a result of several years of study, there are now recommendations under consideration which, if adopted, will substantially change the organization of medical support to the Fleet Marine Force. It is proposed to use physician's assistants rather than physicians at battalion level. The Medical Battalion would become a Force Troops organization, serving the entire MAF (Marine Amphibious Force) rather than a Division organization. Wing surgical assets would be merged with the MAF Medical Battalion. The Force Hospital Company would become a full-service, 200-to-250-bed field hospital and the separate surgical company would be eliminated. The Dental Company would be retained as a Force Troops element.

PREPARATION FOR AUGMENTATION ASSIGNMENT

TEAM PREPARATION

Professional--Each team must take every available opportunity to develop unity and efficiency of the team; this can be done through coordinated effort in actual procedures in hospital assignments or in the simulated combat or disaster environment of medical exercises. The degree to which teamwork is developed in daily routines will be directly reflected in the efficiency of the team when it is deployed.

Administrative--In addition to the professional medical duties of the team members (especially the officer-in-charge), numerous administrative tasks must be accomplished. These tasks reflect directly upon the professional capability of the team and the efficiency of its operation. To simplify or expedite the accomplishment of various administrative tasks, several check lists have been developed and are provided as Appendices A through F. These check lists are designed to specifically identify team members, ensure team compliance with all current directives, and when all items listed are complied with, to ensure the team's ability to rapidly respond to a deployment directive.

Team check lists are presented for:

Appendix	Title
A	Surgical Team (Semiannual Pre-alert Check List)
B	Surgical Team (Mount-out Check List)
C	Surgical Support Team (Semiannual Pre-alert Check List)
D	Surgical Support Team (Mount-out Check List)
E	FMF Surgical Platoon Cadre (Semiannual Pre-alert Check List)
F	FMF Surgical Platoon Cadre (Mount-out Check List)

NOTE: It is recommended that similar check lists be developed for special teams which may be designated.

INDIVIDUAL AUGMENTEE PREPARATION

The individual augmentee assignment presents a most challenging experience to medical personnel. With little notice, augmentees are deployed from their familiar surroundings. They are assigned to a new environment to perform new but related duties under the cognizance of a new supervisor or, in some cases, to perform their assigned duties with little supervision, totally independent of professional medical supervision.

In order to function effectively under these conditions personnel must possess versatility and adaptability. They must be proficient both in their specialties and knowledgeable of the environment in which they will work. The best indicators of potential assignment are Grade/Rank and specialty. Using these as guides the individual augmentee can reasonably predict the type of

assignment he will receive; thus Junior MO's with partial or no specialty training are likely to be assigned as battalion medical officers or ships medical officers. Board eligible or certified surgical, anesthesia specialists are likely to be assigned to field hospitals.

Most individual augmentees are assigned to the FMF. Such individuals should familiarize themselves with FMFM 4-5, Medical and Dental Support, U.S. Marine Corps.

To assist in the preparation of individual augmentees for deployment, individual augmentee check lists have been produced and are presented in Appendices G through J as follows:

Appendix	Title
G	Sponsor's Individual Augmentee (Semiannual Pre-alert Check List)
H	Sponsor's Individual Augmentee (Mount-out Check List)
I	Individual Augmentee (Semiannual Pre-alert Check List)
J	Individual Augmentee (Mount-out Check List)

Year -1 -2
Halves (circle)

SURGICAL TEAM

Semiannual Pre-alert Check List

(To be completed by surgical team senior member)

PERSONNEL

List of Male Personnel Assigned: (fill in)

NOTE # or *	RANK/ GRADE	NAME	SPECIALTY CODE	DUTY
			NOBC 0214	general surgeon
			NOBC 0244	orthopedic surgeon
			NOBC 0613	anesthesiologist
			NOBC 0910	anesthetist (NC)
			NOBC 0970	operating room nurse
			NOBC 0802	administrative officer (MSC)
			HM-0000	general service hospital corpsman
			HM-8417	clinical laboratory technician
			HM-8442	medical administrative technician (HMC)
			HM-8452	medical x-ray technician (HMC or HMI)
			HM-8483	operating room technician (primary NEC)
			HM-8483	"
			HM-8483	"
			HM-8483	operating room technician (primary or secondary NEC)
			HM-8483	"
			HM-8489	orthopedic cast room technician

Footnote to List of Personnel Assigned

Senior member of team.
* Member having FMF experience or Field Medical Service School attendance.

PERSONNEL (continued)

☐ All personnel designated as team members have been notified in writing.

☐ All personnel designated as team members have received surgical team briefing.

☐ All individuals assigned as team members have been immunized in accordance with BUMEDINST 6230.1 series for alert forces.

☐ No individual assigned as a team member has a concurrent assignment for individual augmentee duty nor has his immediate availability been compromised in any way.

☐ Each individual assigned as a team member is receiving adequate and continued training to meet disaster and/or combat readiness criteria.

Each sponsored surgical team has participated in a team exercise:

☐ Locally ☐ In the field ☐ Aboard ships

☐ Training of the surgical team(s) has been conducted (through lectures, audio-visual aids, films, etc.) with emphasis on traumatic surgery.

☐ Training of the surgical team(s) has been conducted to provide surgical care under shipboard and field conditions.

☐ The surgical team(s) has been instructed regarding "Medical Capability Survey and Inventory of the Ships of the Amphibious Force, U.S. Atlantic Fleet," October 1970.

☐ Each individual assigned as a team member has received and has been encouraged to use reference materials, correspondence courses, and training films that are available for his study and which are relative to his training for augmentation duty.

Each individual assigned as a team member has access to and is familiar with the following publications (provided by BUMED to sponsoring hospitals):

- CINCPAC Conferences on War Surgery, Volumes 1 through 5
- Combat and Field Medicine Practice, BUPERS 10817(_) series
- FMFM 4-5 Medical and Dental Support USMC (particularly required for teams 4, 10, 15, and 19)
- Medical Capability Survey and Inventory of the Ships of the Amphibious Force, U.S. Atlantic Fleet, October 1970 (and companion PACFLT Volume when available)
- NATO Handbook for War Surgery

The following records, cards, and tags pertaining to each assigned member of the surgical team(s) have been brought to a current status:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4610150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I. D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

All individuals assigned to surgical teams have been advised to:

_ Check insurance policies and determine that amounts are adequate and beneficiaries are correctly designated.

_ Make certain that allotments are registered to cover all financial obligations, BUPERS Man. 6210120, and to provide the family with money while away.

Check with station legal officer relative to:

_ A valid last will and testament, e.g., proper number of witness signatures according to requirements of various states, etc.

_ Power-of-attorney.

_ Joint bank account (with wife or next of kin).

_ Co-ownership of personal property, such as car, stocks, bonds, real estate, etc.

_ Memo to next of kin regarding location of property or special instruments, such as insurance policies, safety boxes, tax receipts, deeds, etc.

_ Any other personal legal problems.

_ Assure that a ready supply of cash will be available. Delays in drawing pay under emergency situations are frequent.

☐ All individuals assigned to surgical teams are in a physically fit status for deployment.

☐ All individuals assigned to surgical teams possess and maintain their required quantity of uniforms and accessories in readiness for deployment.

SURGICAL SUPPLY BLOCK

☐ All surgical material is packed and sterilized in accordance with instructions in BUMED AMAL 635.

☐ Consideration was given to local tailoring of assigned supply blocks to accommodate specialized techniques or training of team personnel.

☐ All assigned supply blocks have been updated to conform with latest revised allowance list received from Field Branch, BUMED.

☐ Sterility tests of prepackaged sterile surgical packs were conducted during last __ February, __ August.

☐ Within 30 days preceding the report date ___ 1 March, ___ 1 September, familiarization procedures with contents and functional packing concepts of the surgical team supply block material were conducted. Reference: BUMESINST 6440.1 series, paragraph 7h.

☐ Material was restored to a condition of readiness for immediate deployment and use.

☐ Report was submitted by the Command to BUMED on material readiness of each surgical block under cognizance: ___ 1 March; ___ 1 September.

☐ Copy of material readiness report was submitted to Field Branch,

BUMED
3500 South Broad Street ___ 1 March; ___ 1 September
Philadelphia, Pa. 19145

ORDERS/TRANSPORTATION

☐ Orders are prepared and are on file for transportation of each team member to destination when ordered to be deployed. Destination and reporting instructions are to be completed when the team is deployed. Security certification is included as appropriate.

☐ Transportation means and procedure for shipment of the surgical team supply block to various locations has been identified.

For Surgical Teams 4, 10, 15, and 19

☐ An FMF Surgical Platoon Cadre, Semiannual Pre-alert Check List has been completed (see Appendix E.)

SURGICAL TEAM

Mount-out Check List

(To be completed by surgical team senior member)

PERSONNEL

List of Personnel assigned: (fill in)

NOTE # or *	RANK/ GRADE	NAME	SPECIALTY CODE	DUTY
			NOBC 0214	general surgeon
			NOBC 0244	orthopedic surgeon
			NOBC 0613	anesthesiologist
			NOBC 0910	anesthetist (NC)
			NOBC 0970	operating room nurse
			NOBC 0802	administrative officer (MSC)
			HM-0000	general service hospital corpsman
			HM-8417	clinical laboratory technician
			HM-8442	medical administrative technician (HMC)
			HM-8452	medical x-ray technician (HMC or HMI)
			HM-8483	operating room technician (primary NEC)
			HM-8483	"
			HM-8483	"
			HM-8483	operating room technician (primary or secondary NEC)
			HM-8483	"
			HM-8489	orthopedic cast room technician

Footnote to List of Personnel Assigned

Senior member of team.
* Member having FMF experience or Field Medical Service School attendance.

PERSONNEL (Continued)

☐ All team members have been notified (individually) regarding their alert status and regarding changes in the alert status.

☐ All individual team members are in a physically fit status for deployment.

The following records, cards, and tags pertaining to each assigned member of the surgical team(s) have been brought to a current status:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunication Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4610150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I. D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

☐ Each individual team member possesses and maintains his required quantity of uniforms and accessories in readiness for deployment.

☐ TAD orders are issued to each individual team member in accordance with BUPERSINST 5400.42 series and NAVPERS 15909(_) series, Navy Enlisted Transfer Manual.

☐ Individual team members have been directed to report to their appropriate commander or officer-in-charge at their destination for additional TAD augmentation assignment.

☐ Deployment travel of individual team members has been certified for Class I priority travel in government aircraft. If no government aircraft was available, travel by commercial air has been certified.

☐ The commander requesting the surgical team has been alerted regarding transportation requirements.

☐ Station to departure point and interim transportation transfer has been arranged.

☐ Plans have been developed for arrival at the destination including reporting and a preliminary plan of operation.

SURGICAL SUPPLY BLOCK

- ☐ Perishable and deteriorable items have been prepared and included in the surgical supply block.
- ☐ The surgical supply block has been prepared and staged (if required) for quick departure.
- ☐ Arrangements have been made for material handling equipment (as required) such as fork lifts, dollys, etc.
- ☐ A confirmation report on material readiness of the team supply block was submitted to BUMED.

TRANSPORTATION:

- ☐ The transportation agency (for personnel and for supply block) has been alerted.
- ☐ Transportation from duty station to departure point and interim transportation has been arranged.

Year -1 -2
Halves (circle)

SURGICAL SUPPORT TEAM

Semiannual Pre-alert Check List

(To be completed by sponsoring activity)

PERSONNEL

List of Male Personnel Assigned: (fill in)

NOTE # or *	RANK/ GRADE	NAME	SPECIALTY CODE	DUTY
			NOBC 0070	general medical officer
			NOBC 0945	nurse
			HM-0000	general service hospital corpsman
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"

Footnote to List of Personnel Assigned

Senior member of team.
* Member having FMF experience or Field Medical Service School attendance.

PERSONNEL (continued)

☐ All individuals assigned as team members have been notified in writing.

☐ All individuals assigned as team members have received a surgical support team briefing.

☐ All individuals assigned as team members have been immunized in accordance with BUMEDINST 6230.1 series for alert forces.

☐ No medical officer assigned as a team member will have his residency training interrupted (desirable).

☐ No individual assigned as a team member has a concurrent assignment for individual augmentee duty nor has his immediate availability been compromised in any way.

☐ Each individual assigned as a team member is receiving adequate and continued training to meet disaster and/or combat readiness criteria.

Each sponsored surgical support team has participated in a team exercise:

☐ Locally ☐ In the field ☐ Aboard ships

☐ Training of the surgical support team(s) has been conducted (through lectures, audio-visual aids, films, etc.) with emphasis on traumatic surgery.

☐ Training of the surgical support team(s) has been conducted to provide surgical support care under shipboard and field conditions.

☐ The surgical support team(s) has been instructed regarding "Medical Capability Survey and Inventory of the Ships of the Amphibious Force, U.S. Atlantic Fleet," October 1970.

☐ Each individual assigned as a team member has received and has been encouraged to use reference materials, correspondence courses and training films that are available for his study and which are relative to his training for augmentation duty.

Each individual assigned as a team member has access to and is familiar with the following publications (provided by BUMED to sponsoring hospitals):

- CINCPAC Conferences on War Surgery, Volumes 1 through 5
- Combat and Field Medicine Practice, BUPERS 10817(_) series
- FMFM 4-5 Medical and Dental Support USMC (particularly required for teams 4, 10, 15, and 19)
- Medical Capability Survey and Inventory of the Ships of the Amphibious Force, U. S. Atlantic Fleet, October 1970 (and companion PACFLT Volume when available)
- NATO Handbook for War Surgery

The following records, cards, and tags pertaining to each assigned member of the surgical team(s) have been brought to a current status:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4610150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I. D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

All individuals assigned to surgical support teams have been advised to:

_ Check insurance policies and determine that amounts are adequate and beneficiaries are correctly designated.

_ Make certain that allotments are registered to cover all financial obligations, BUPERS Man. 6210120, and to provide the family with money while away.

Check with station legal officer relative to:

_ A valid last will and testament, e.g., proper number of witness signatures according to requirements of various states, etc.

_ Power-of-attorney.

_ Joint bank account (with wife or next of kin).

_ Co-ownership of personal property, such as car, stocks, bonds, real estate, etc.

_ Memo to next of kin regarding location of property or special instruments, such as insurance policies, safety boxes, tax receipts, deeds, etc.

_ Any other personal legal problems.

_ Assure that a ready supply of cash will be available. Delays in drawing pay under emergency situations are frequent.

☐ All individuals assigned to surgical teams are in a physically fit status for deployment.

☐ All individuals assigned to surgical teams possess and maintain their required quantity of uniforms and accessories in readiness for deployment.

ORDERS/TRANSPORTATION

☐ Orders are prepared and are on file for each team member so that delay in deployment will be minimized.

SURGICAL SUPPORT TEAM

Mount-out Check List

(To be completed by surgical support team senior member)

PERSONNEL

List of Male Personnel Assigned: (fill in)

NOTE # or *	RANK/ GRADE	NAME	SPECIALTY CODE	DUTY
			NOBC 0070	general medical officer
			NOBC 0945	nurse
			HM-0000	general service hospital corpsman
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"
			HM-0000	"

Footnote to List of Personnel Assigned

Senior member of team
* Member having FMF experience or Field Medical Service School attendance.

PERSONNEL (continued)

☐ All team members have been notified (individually) regarding their alert status and regarding changes in the alert status.

☐ All individual team members are in a physically fit status for deployment.

The following records, cards, and tags pertaining to each assigned member of the surgical team(s) have been brought to a current status:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4510150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I. D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

☐ Each individual team member possesses and maintains his required quantity of uniforms and accessories in readiness for deployment.

☐ TAD orders are issued to each individual team member in accordance with BUPERSINST 5400.42 series and NAVPERS 15909(_) series, Navy Enlisted Transfer Manual.

☐ Individual team members have been directed to report to their appropriate commander or officer-in-charge at their destination for additional TAD augmentation assignment.

☐ Deployment travel of individual team members has been certified for Class I priority travel in government aircraft. If no government aircraft was available, travel by commercial air has been certified.

☐ The commander requesting the surgical team has been alerted regarding transportation requirements.

☐ Station to departure point and interim transportation transfer has been arranged.

☐ Plans have been developed for arrival at the destination including reporting and a preliminary plan of operation.

Year -1 -2
Halves (circle)

FMF SURGICAL PLATOON CADRE

Semiannual Pre-alert Check List

(To be completed by sponsoring activity)

NOTE: Surgical team numbers 4, 10, 15, and 19 are dual-purpose teams and each may be deployed as a surgical team or as an FMF Surgical Platoon Cadre. Consequently, all members, except the two augmented members required exclusively for the cadre, must be trained and qualified for the functions of both team and cadre

PERSONNEL

List of Male Personnel Assigned (fill in)

NOTE # or *	RANK/ GRADE	NAME	SPECIALTY CODE	DUTY
			NOBC 0214	general surgeon
			NOBC 0244	orthopedic surgeon
			NOBC 0613	anesthesiologist
			NOBC 0910	anesthetist (NC)
			NOBC 0970	operating room nurse
			NOBC 0802	administrative officer (MSC)
			HM-0000	general service hospital corpsman
			HM-8417	clinical laboratory technician
			HM-8442	medical administrative technician (HMC)
			HM-8452	medical x-ray technician (HMC or HMI)
			HM-8483	operating room technician (primary NEC)
			HM-8483	"
			HM-8483	"

PERSONNEL (Continued)

NOTE # or *	RANK/ GRADE	NAME	SPECIALTY CODE	DUTY
			HM-8483	operating room technician (primary or secondary NEC)
			HM-8483	"
			HM-8483	"
			HM-8489	orthopedic cast room technician
			HM-8482	pharmacy technician

Footnote to List of Personnel Assigned

Senior member of team.
* Member having FMF experience or Field Medical Service School attendance.

☐ All individuals assigned as cadre members have been notified in writing.

☐ All individuals assigned as cadre members have received an FMF Surgical Platoon Cadre briefing.

☐ All individuals assigned as cadre members have been immunized in accordance with BUMEDINST 6230.1 series for alert forces.

☐ No medical officer assigned as a cadre member will have his residency training interrupted (desirable).

☐ No individual assigned as a cadre member has a concurrent assignment for individual augmentee duty nor has his immediate availability been compromised in any way.

☐ Each individual assigned as a cadre member is receiving adequate and continued training to meet disaster and/or combat readiness criteria.

Each sponsored FMF Surgical Platoon Cadre has participated in a team exercise:

☐ Locally ☐ In the field ☐ Aboard ships

☐ Training of the FMF Surgical Platoon Cadre has been conducted through lectures, audio-visual aids, films, etc., with emphasis on traumatic surgery.

☐ Training of the FMF Surgical Platoon Cadre has been conducted to provide surgical care under field conditions.

☐ Each individual assigned as a team member has received and has been encouraged to use lists of reference materials, correspondence courses, and training films that are available for his study and which are relative to his training for augmentation duty.

☐ Each individual assigned as a cadre member has access to and is familiar with the following publications (provided by BUMED to sponsoring hospitals):

- CINCPAC Conferences on War Surgery, Volumes 1 through 5
- Combat and Field Medicine Practice, BUPERS 10817(_) series
- FMFM 4-5 Medical and Dental support USMC (particularly required for teams 4, 10, 15, and 19)
- Medical Capability Survey and Inventory of the Ships of the Amphibious Force, U. S. Atlantic Fleet, October 1970 (and companion PACFLT Volume when available)
- NATO Handbook for War Surgery

☐ All cadre members without previous FMF experience have been nominated to receive an indoctrination course at a Field Medical Service School.

☐ A field exercise of the FMF Surgical Platoon Cadre has been conducted during the last 12 months with the Division or Brigade Surgeon of the local garrison forces.

The following records, cards, and tags pertaining to each assigned member of the cadre have been brought to a current status:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4610150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I. D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

All individuals assigned to the cadre have been advised to:

_ Check insurance policies and determine that amounts are adequate and beneficiaries are correctly designated.

_ Make certain that allotments are registered to cover all financial obligations, BUPERS Man. 6210120, and to provide the family with money while away.

Check with station legal officer relative to:

_ A valid last will and testament, e.g., proper number of witness signatures according to requirements of various states, etc.

_ Power-of-attorney.

_ Joint bank account (with wife or next of kin).

_ Co-ownership of personal property, such as car, stocks, bonds, real estate, etc.

_ Memo to next of kin regarding location of property or special instruments, such as insurance policies, safety boxes, tax receipts, deeds, etc.

_ Any other personal legal problems.

_ Assure that a ready supply of cash will be available. Delays in drawing pay under emergency situations are frequent.

☐ All individuals assigned to surgical teams are in a physically fit status for deployment.

☐ All individuals assigned to surgical teams possess and maintain their required quantity of uniforms and accessories in readiness for deployment.

ORDERS/TRANSPORTATION

☐ Orders are prepared and are on file for transportation of each cadre member when ordered to be deployed. (Destination and reporting instructions are to be completed when the cadre is deployed.) Security certification is included as appropriate.

FOR SURGICAL TEAMS 15 and 19

☐ A prospective company commander (one CDR 2100) has been nominated and trained to serve if the team is activated as an FMF Surgical Platoon Cadre and if BUMED requires this officer for the assigned mission.

FMF SURGICAL PLATOON CADRE

APPENDIX F

Mount-out Check List

(To be completed by FMF Surgical Platoon Cadre senior member)

PERSONNEL

List of Male Personnel Assigned: (fill in)

NOTE # or *	RANK/ GRADE	NAME	SPECIALTY CODE	DUTY
			NOBC 0214	general surgeon
			NOBC 0244	orthopedic surgeon
			NOBC 0613	anesthesiologist
			NOBC 0910	anesthetist (NC)
			NOBC 0970	operating room nurse
			NOBC 0802	administrative officer (MSC)
			HM-0000	general service hospital corpsman
			HM-8417	clinical laboratory technician
			HM-8442	medical administrative technician (HMC)
			HM-8452	medical x-ray technician (HMC or HMI)
			HM-8483	operating room technician (primary NEC)
			HM-8483	"
			HM-8483	"
			HM-8483	operating room technician (primary or secondary NEC)
			HM-8483	"
			HM-8483	"
			HM-8489	orthopedic cast room technician
			HM-8482	pharmacy technician

Footnote to List of Personnel Assigned

#Senior member of cadre.
*Member having FMF experience or Field Medical Service School attendance.

PERSONNEL (continued)

☐ All team members have been notified (individually) regarding their alert status and regarding changes in the alert status.

☐ All team members are physically fit for deployment.

Check the following records, cards, and tags for all alerted individual team members for currency and completeness:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4610150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I. D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

☐ Each individual team member possesses and maintains his required quantity of uniforms and accessories in readiness for deployment.

☐ TAD orders are issued to each individual team member in accordance with BUPERSINST 5400.42 series and NAVPERS 15909(_) series, Navy Enlisted Transfer Manual.

☐ Individual team members have been directed to report to their appropriate commander or officer-in-charge at their destination for additional TAD augmentation assignment.

☐ Deployment travel of individual team members has been certified for Class I priority travel in government aircraft. If no government aircraft was available, travel by commercial air has been certified.

☐ The commander requesting the surgical team has been alerted regarding transportation requirements.

☐ Station to departure point and interim transportation transfer has been arranged.

☐ Plans have been developed for arrival at the destination including reporting and a preliminary plan of operation.

FOR SURGICAL TEAMS 15 AND 19

☐ A prospective company commander (one CDR 2100) has been nominated and trained to serve if the team is activated as an FMF Surgical Platoon Cadre and if BUMED requires this officer for the assigned mission.

Year (indicate) _____
-1 -2
Halves (circle)

SPONSOR'S INDIVIDUAL AUGMENTEE
Semiannual Pre-alert Check List

(To be completed by sponsoring activity)

☐ All individuals required by SECNAVINST 6440.1 series or requested by NAVPERS or BUMED have been selected for individual augmentee duty.

☐ All individuals selected as individual augmentees have been notified in writing.

☐ All individuals selected as individual augmentees have been immunized in accordance with BUMEDINST 6230.1 series for alerted forces.

☐ No medical officer selected for individual augmentee duty will have his residency training interrupted (desirable).

☐ No individual selected for individual augmentee duty has a concurrent augmentation assignment as a member of a medical team nor has his immediate availability been compromised in any way.

☐ Each individual designated for individual augmentee duty has received a complete indoctrination course relating to his duties as an augmentee.

☐ Each designated augmentee has received a list of augmentee related reference materials, correspondence courses and training films that are available for his use.

☐ Each individual (without previous FMF experience) designated for individual augmentee duty has been ordered to attend appropriate courses in Field Medical Service School at Camp Lejeune or Camp Pendleton. Note: this is to be accomplished when staffing, time, and TAD funds permit.

The following records, cards, and tags pertaining to all individuals designated for individual augmentee duty have been brought to a current status:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4610150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I. D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

Each individual designated for augmentee duty has been advised to:

_ Check insurance policies and determine that amounts are adequate and beneficiaries are correctly designated.

_ Make certain that allotments are registered to cover all financial obligations, BUPERS Man. 6210120, and to provide the family with money while away.

Check with station legal officer relative to:

_ A valid last will and testament, e.g., proper number of witness signatures according to requirements of various states, etc.

_ Power-of-attorney.

_ Joint bank account (with wife or next of kin).

_ Co-ownership of personal property, such as car, stocks, bonds, real estate, etc.

_ Memo to next of kin regarding location of property or special instruments, such as insurance policies, safety boxes, tax receipts, deeds, etc.

_ Any other personal legal problems.

_ Assure that a ready supply of cash will be available. Delays in drawing pay under emergency situations are frequent.

☐ Each individual designated for augmentee duty is physically fit for deployment.

☐ Each individual designated for augmentee duty possess and maintains his required quantity of uniforms and accessories in readiness for deployment.

ORDERS/TRANSPORTATION

☐ Orders are prepared (with blanks to be completed) and are on file for completion when orders are received to deploy the augmentees.

SPONSOR'S INDIVIDUAL AUGMENTEE

Mount-out Check List

(To be completed by sponsoring activity)

☐ All individuals affected have been notified regarding the alert status and regarding changes in the alert status.

☐ All individual are physically fit for deployment.

The following records, cards, and tags for all alerted individuals designated for individual augmentee duty are current and complete and prepared for delivery (if appropriate) to the individual:

_ Official Passport (certain teams only)

_ Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 is held by each person. (See current BUMEDINST 6230.1 series re: Immunization Requirements and Procedures.)

_ Dental Record--the Standard Form 103 is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

_ Service Record--the record of emergency data, NAVPERS 1070/602, November 1969, is up-to-date.

_ Pay Record--allotments have been registered to cover insurance, bonds, dependents, etc., and have been forwarded to the Navy Finance Center.

_ Identification Tags--(BUPERS Man. 4610150.)

_ Identification Card--DD Form 2N Active, is current. (BUPERS Man. 4620150.)

_ Geneva Convention I.D. Card--DD Form 528 (BUPERS Man. 4620100) is immediately available for each person.

_ Secret security clearances have been obtained or requested for all senior medical personnel.

☐ Each individual designated for individual augmentee duty possesses his required quantity of uniforms and accessories in readiness for deployment.

☐ TAD orders are prepared (per BUPERSINST 5440.42 series, and NAVPERS 15909(_) series, Navy Enlisted Transfer Manual) for issue to each augmentee.

☐ Individuals designated for individual augmentee duty have been specifically instructed regarding to whom they shall report at their new duty assignment.

☐ Deployment travel of individuals designated for individual augmentee duty has been certified for Class I priority travel in government aircraft or if government air transportation is not available, travel by commercial air has been certified.

☐ The commanding officer requesting the individual augmentee has been alerted regarding personnel and baggage to be transported.

☐ Station to departure point and interim transportation transfer has been arranged.

☐ Augmentees have been briefed (within security limitations and available knowledge) regarding their destination and their anticipated duties.

Year -1 -2
Halves (circle)

RANK/GRADE NAME SPECIALTY

INDIVIDUAL AUGMENTEE

Semiannual Pre-alert Check List

(To be completed by the designated individual)

☐ I have received notification in writing that I am a candidate for augmentee assignment.

☐ I have received the immunization required for alert forces (BUMEDINST 6230.1 series).

☐ I have reported any conflicting assignment which may interfere with my immediate availability for augmentee assignment to my commanding officer.

☐ I have received an indoctrination course relating to assignment to augmentee duty.

☐ I have received lists of available reference materials, correspondence courses, and training films pertaining to augmentation duty.

☐ I have previous FMF experience or:

☐ I have received orders to attend appropriate courses in Field Medical Services at Camp Lejeune or Camp Pendleton.

☐ I have been advised that orders have been prepared for me and are on file for my immediate use when I am ordered to be deployed as an individual augmentee.

☐ I have performed the required functions to ensure that the following records, cards, and tags pertaining to me are current:

Health Record--has been verified and is current with regard to all required immunizations. Immunization Card DD Form 737 should be held by each person. (See current BUMEDINST 6230.1 series.)

Dental Record--Standard Form 103, is up-to-date (valuable means of identification). (BUMED Man. 6-107-8.)

Service Record--my record of emergency data, NAVPERS 1070/602 November 1969, is up-to-date.

Pay Record--all allotments required by me have been registered (insurance, bonds, dependents, etc.) and have been forwarded to the Navy Finance Center.

I have identification tags--(BUPERS Man. 4610150.)

I have an identification card--DD Form 2N Active and it is current. (BUPERS Man. 4620150.)

A Geneva Convention Card--DD Form 528 (BUPERS Man. 4620100) has been prepared for me.

_ I have executed the required forms to obtain secret security clearance.

I have been advised to:

_ Check insurance policies and determine that amounts are adequate and beneficiaries are correctly designated.

_ Make certain that allotments are registered to cover all financial obligations, and to provide my family with money while I am away. (BUPERS Man. 6210120.)

I have checked with the legal officer relative to:

_ Execution of a valid last will and testament, e.g., proper number of witness signatures according to requirements of various states, etc.

_ Execution of a power-of-attorney.

_ Establishment of a joint bank account (with wife or next of kin).

_ Assignment of co-ownership of personal property, such as car, stocks, bonds, real estate, etc.

_ Execution of a memo to my next of kin regarding location of property or special instruments, such as insurance policies, safety boxes, tax receipts, deeds, etc.

_ Clarifying or resolving any other personal legal problems.

☐ Assure that I have a ready supply of cash available for my personal requirements. Delays in drawing pay under emergency situations are frequent.

☐ I am physically fit for deployment for individual augmentation duty.

☐ I possess the required quantity of uniforms and accessories in readiness for my deployment.

RANK/GRADE NAME SPECIALTY

INDIVIDUAL AUGMENTEE

Mount-out Check List

(To be completed by designated individual)

☐ I have received notification of being placed on an alert status.

☐ I make periodic inquiries regarding changes in the alert status and keep my immediate supervisor advised of the location at which I may be contacted.

☐ I am physically fit for deployment.

I have the following records, cards, and tags in my possession, and have verified that they are complete and current:

_ Health Record--Immunization Card DD Form 737

_ Dental Record--Standard Form 103

_ Service Record--NAVPERS 1070/602

_ Pay Record

_ Identification Tags

_ Identification Card--DD Form 2N Active

_ Geneva Convention I.D. Card--DD Form 528

_ Orders which certify my secret security clearance, if appropriate.

☐ I possess (and have packed for deployment) the required quantity of serviceable uniforms.

☐ I have received my TAD orders.

☐ I have received and understand the directive requiring me to report to my new commander at the specified destination.

☐ My deployment travel orders are certified for Class I priority travel in government aircraft and indicate that if government air travel is not available I may travel by commercial air.

☐ I have planned for my arrival at the designated destination and understand the procedures for reporting.